MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

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9:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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CAROL RAPHAEL
ALICE ROSENBLATT
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

MR. HACKBARTH: Good morning and welcome to our guests, our many guests I guess I should say.

Today we will proceed through a series of discussions related to our recommendations on update factors for the various categories of providers. We are scheduled to have our public comment period at noon. Obviously that may be moved a little bit depending on how we proceed through the agenda.

This morning we begin with post-acute services, SNF and home health services. And then right before lunch we will turn to physician, outpatient dialysis and ambulatory surgical centers and then break for lunch. Then this afternoon we will address the hospital recommendations. And at the end of the day we will have a brief discussion on the chapter on paying for new technologies. And then a final public comment period, which is currently scheduled for about 4:30 p.m.

So we begin with SNF services, Susanne and Sally, whenever you're ready, go ahead. You look puzzled, Sally.

I forgot that Mark had a brief announcement. Thanks.

DR. MILLER: I'll do this in 10 seconds or less.

MR. HACKBARTH: So Jack is going to introduce the

hospital payment issues. Jack?

MR. ASHBY: I'm going to begin by changing the order of the presentations that we're going to do in the hospital sector this afternoon over what appeared on the agenda. We're going to begin with a brief discussion of margin concepts and then Tim will follow immediately with the actual margins data. That will segue into our discussion of payment adequacy for the hospital as the whole, which in turn supports all five of the policy decisions that appear here as items three through eight in our discussion.

This approach with the payment adequacy proceeding both the distributional issues and the update is how we laid out our chapter, by the way.

Just a very brief moment on the concept of margin. We define margin as the share of an organization's revenue that it gets to keep and the formula is, very simply, revenue minus costs divided by revenue.

For hospital analyses we do indeed use several different margins but each has its own purpose. In short, different questions call for different margins. So while the pattern may not always be evident, we use the various margins in a consistent way, or at least we try to do so. So this afternoon I'm going to first identify the margins at issue of this slide and then go through and try to explain how each of them is used.

All of the margin measures you see here use the same formula. They differ only in the services and the payers that they cover. The total margin includes all services and all payers, and that even includes non-paying patients and also covers non-patient revenue where there is essentially no service involved. Investment income and donations are examples of revenues where there's essentially no associated service.

Then the overall Medicare margin is intended to cover all of fee-for-service Medicare, but in fact it does omit a handful of small services like hospice and ambulance. Then we have the five component margins that come together to form the overall Medicare margin. We have the Medicare inpatient that covers inpatient services within the PPS; the Medicare outpatient; the PPS-exempt. That encompasses inpatient, psychiatric and rehab units. And then finally, the margins for hospital-based SNF and home health.

Moving to the uses, our policy basically on the

total margin is that there is no direct role for the total margin in Medicare payment policy decisions. But the total margin does provide us with useful context information so we do track the trend in total margin for the industry.

We have three different data sources for our total margin. Unfortunately, the three sources do sometimes produce different values, but that's not because they're measuring anything different but because of differences in the samples and also differences in the years. What we define as 2000 differs from source to source.

The primary source that we use is the Medicare cost report of course, and we have data through fiscal year 2000. Then we also have a value from the American Hospital Association annual survey, and that's more recent. It's a 2001 value. Then finally we have our National Hospital Indicator Survey. CMS and MedPAC sponsor this survey together and it's conducted by the AHA. In theory, this should be the most useful of the three calculations because it's the most recent. We actually have data for three quarters of 2002. But we also have to note that it has the smallest sample so it presumably has the largest margin of error around values.

Generally we use the overall Medicare margin to track how Medicare's payment relate to the allowable costs of treating Medicare beneficiaries. Then more specifically, we use it to assess Medicare payment adequacy for the hospital as a whole. As we've talked about before, this is necessary because of bias in the allocation of cost among components.

I want to emphasize that we wouldn't use this approach. We would probably want to assess payment adequacy for each component with its own margin if we thought that each component margin would give us an accurate reflection of how payments and costs relate in the absolute. But in fact we can't do that because all evidence points to the fact that the inpatient margin is biased upward and all four of the other margins are biased downward.

Some observers have expressed concern that we're more likely to note the downward bias in the outpatient margin. That may be just human nature when we see those big negatives, but in fact it is equally important that we note that there is bias in both directions among the components.

Given that allocation bias, that leads to an important question, why use the component margins at all?

We think there are three situations where the inpatient or the outpatient margin offers more useful information than we would get from the overall Medicare margin alone.

First, the component margins allow us to track changes in the mix of payments. If the inpatient margin were going up and the outpatient down, or vice versa, the changes might very well offset each other and be masked by the change in the overall margin. That's not just a theoretical possibility. That in fact is what happened in our latest round of data as Tim will be showing you shortly. It's only by looking at the change in the component margins that we even become aware of this very important shift in revenues.

Second, the inpatient or outpatient margin allows us a more focused comparison of hospital groups when we're considering a distributional policy change. The key word here is distributional. We use the overall Medicare margin for questions of payment adequacy. That's when we're looking at the amount of money in the system overall. We use the component margins when we're looking at distributional issues where a comparison among groups or individual hospitals is the important issue.

Seeing the benefit of that is easiest when you think about what would be involved in an outpatient policy change. The change in the overall Medicare margin might appear minuscule when in fact the policy change is having a major effect in the outpatient sector.

Then the third reason, which is probably the least important of the three, is that the inpatient margin documents the trend prior to 1996 when, unfortunately, the overall Medicare margin was not available to us. If we had historical information on the overall, that's clearly what we would show in the context of payment adequacy.

Actually before I turn to that next slide I wanted to make a sidebar note here that on the inpatient margin we do have a special calculation that you've seen several times of the inpatient margin excluding disproportionate share payments and the portion of the IME above the cost of teaching. Just as the costs and payments of other sectors confound our comparison of groups when we're looking at the inpatient margin, the DSH and above-cost IME payments also confound the comparison when we're looking at an issue that has to do with the inpatient base rates.

The best example of that is our proposal to

eliminate the differential in the base rates. It was only when we took the DSH and the above-cost IME payments and put them out to the side that we could even see that there is in fact a substantial difference in the inpatient margin between large urban, other urban, and rural hospitals. Without that separation, it was so confounded by IME and DSH that just basically the information was useless.

We also have used this margin, excluding DSH and above-cost IME, we've also used it in our transfer policy analysis that is coming up where again the scenario here is that the DSH and the IME are essentially just not relevant to the analysis, so we put them aside so that we can focus on a measurement that will not be confounded by these other revenues.

Then our last slide here deals with one last issue, and that is projecting margins. Our model for assessing payment adequacy, as you've heard this morning in the other sectors, calls for an estimate of current payments and costs. So we project the overall margin to 2003 for this purpose. We did not project the individual component margins. First of all, it's not needed for our assessment of payment adequacy. But secondly, it would not be accurate given our projection approach. We end up projecting costs for the hospital as a whole and not by service line.

So that the concepts. If there's any questions on that we might wonder to address questions, and otherwise we'll move on to the actual data.

MR. GREENE: Good afternoon. Today I will be reviewing MedPAC's analysis of hospital financial performance in general and for services provided to Medicare beneficiaries. I will then review our work on the adequacy of Medicare payment for all services provided by hospitals paid under the inpatient PPS. After my presentation you'll hear discussions of the IME, the expanded transfer policy and MedPAC's rural recommendations. I'll then return and present draft recommendations for the payment update for inpatient services. Chantal will come after me and discuss payment update recommendations for outpatient.

The general financial health of hospitals is not an indicator of the adequacy of Medicare payments for services provided to beneficiaries. However, it is an important piece of background information in considering the context of the Commission's update recommendation. In analyzing it we consider the impact of policies of all

private and public payers.

Total margin reached a high of 6.1 percent in fiscal 1996 and averaged 4.6 percent for the full decade from 1990 through 2000. In fiscal 2000 it feel to 3.4 percent , a low for the decade.

MedPAC examined data from the American Hospital Association on developments since 2000. The decline in the total margin appears to have halted in fiscal 2000. We examined data from the AHA annual survey, which collects information from approximately 5,100 community hospitals. The annual survey indicates that the total margin fell in 2001 from 4.6 percent to 4.2 percent.

We then looked at the National Hospital Indicator Survey. The NHIS is a quarterly survey of approximately 700 hospitals conducted by AHA with support from CMS and MedPAC. NHIS data are the most current information on hospital financial performance. We used the NHIS data for the first three quarters of fiscal year 2002 to identify the direction of change in the total margin. We seasonally adjusted the data and estimate the total margin for fiscal 2002. Our estimate is that the total margin will equal 4.5 percent for full fiscal year 2002 which is equal to the value for 2001.

Let me note that these analyses so far are based entirely on actual data. The real data as collected and imputations by the survey questions.

DR. NEWHOUSE: Tim, can I ask you a question? Do you know if the cost data that you're using in the margin accounts for changes in reserves from year to year?

MR. GREENE: I'm not sure.

DR. ROWE: This is P&L, right?

DR. NEWHOUSE: No, it's revenue but it's costs.

MR. ASHBY: It has to be a current year expense.

MS. ROSENBLATT: Change hits the P&L.

MR. MULLER: If there's an operating loss that would show as a P&L negative, but it depends on how that is funded and so forth.

MS. ROSENBLATT: You're asking about changes in accruals, right? Changes in accruals would hit the cost --

DR. ROWE: No, I thought he was talking about reserves. This isn't an insurance company. This is a hospital.

[Laughter.]

MS. ROSENBLATT: That's why I changed the word to accrual.

DR. NEWHOUSE: No, she's got what I'm talking about.

MR. GREENE: We next looked at information from the fiscal year 2000 Medicare cost reports to examine Medicare financial performance. We analyzed margins for the major components of short-term hospitals. Hospital inpatient margins declined and outpatient margins increased from fiscal year 1999 to fiscal year 2000. This was accompanied by increases in the PPS-exempt and home health margins and decreases in the skilled nursing facility margins. There was a modest decline in the overall Medicare margin.

These measures are based on the most recently available cost reports with imputation of data for non-reporting hospitals. They're for hospital-based services only and differ from the results for freestanding skilled nursing facilities and home health agencies which you heard earlier.

Information on the Medicare inpatient margin is available from 1984 on. As Jack was describing, the overall margin is not available because of data limitations before fiscal year 1996. Because inpatient payments account for approximately three-quarters of total Medicare payments to PPS hospitals, the inpatient and overall margins followed very similar trends. The inpatient margin increased steadily from 1991 to 1996. Both inpatient and overall margins then increased further in 1997 then began a decline to 2000. Inpatient margin reach a high of 10.4 percent in 1997 and the overall margin high of 16.5 percent.

The overall Medicare margin was 5.1 percent in 1999 and 5.0 percent in 2000. The fell in rural and other urban areas. Overall margins for major teaching hospitals improved while those of other teaching and non-teaching hospitals declined. I'll note that the numbers differ slightly from the information in your briefing material. As we said, this updated information reflects imputations of data that were not available at the time we prepared the mailing material.

We estimate that the overall Medicare margin will be 3.I percent in 2003. Rural margins improve in 2003 while other hospitals see declines. These results reflect policy changes taking effect in 2003 and scheduled for 2004, the year for which we're considering an update decision. Major changes include the reduction in the IME adjustment and the

end of transitional corridor payments under the outpatient PPS.

These results differ from the ones you saw in December. The results last month used fiscal year 1999 data to model fiscal year 2000 results. We're now using the new 2000 cost reports, the most recent available, to model 2003. And as indicated, now we're imputing data from missing hospitals. We've also taken account of changes we had not reflected in our December analysis. That study incorporated information on updates in law and most policy changes from 2001 through 2004. These changes had not been reflected in the 2000 cost report data and for that reason we need to take them into account for the purpose of projecting the 2003 results.

We now model other policies that we didn't consider in December. These include the end of transition payments in the outpatient PPS, as I indicated, the phase-in of the SNF and home health prospective payment systems, and the impact of closures of hospital-based SNFs on Medicare payments and costs. Some of these changes increase overall margins and others decrease them.

Now I'm turning to several elements of our payment adequacy framework which I'll go through quickly.

Hospital cost growth is accelerated with both Medicare cost per case and cost per adjusted admission starting to grow rapidly in 1999. AHA data indicate the cost per adjusted admission increased 16 percent over the decade of the '90s, fell about 4 percent in the middle of the decade, 1996 to 1998, and then increased steadily through 2000. New AHA data indicates that cost grew 4.7 percent in 2002 alone. NHIS data suggests that the cost increase continued in fiscal 2002. Medicare cost per case growth was modest in the mid-'80s, but once again, accelerated at the end to 3 percent per year in '99 and 2.9 percent in 2000, the most recent year for which we have cost report data.

Increasing cost per adjusted admission and Medicare cost per case were moderated in the '90s by length of stay decline. We discussed this a bit last time. We now see the length of stay decline we were observing through much of the '90s appears to have moderated. Both overall and Medicare length of stay continued to decline but at a slower and less reliable rate. For example, stay for all patients declined 1.8 percent in 2000, 1.3 present the next

year, and may be stabilizing in fiscal 2002. The Medicare length of stay decline continued but may also have flattened out in fiscal 2002.

Wages are the largest component of the hospital marketbasket. As a result, wage growth has contributed significantly to higher overall cost growth. This has been accompanied by shortages of occupations such as nurses, pharmacists, therapists, and other health care occupations. Hospital industry wages rose more rapidly than wages in the general economy in 2001 and 2002, in very strong contrast to a trend that had prevailed through most of the 1990s. The employment cost index, or ECI, for wages and salaries of hospital workers is our best measure of hospital wages and it's now used in the CMS marketbasket. This measure increased 5.4 percent in 2001 and 4.4 percent in 2002. However, it's predicted to increase but increase at a steadily declining rate of 4 percent in 2004.

An additional factor affecting hospital cost is reflected in the market for hospital services. Increased revenue pressure from private payers through the 1990s helped produce low hospital cost growth. More recently, relaxed pressure has permitted hospitals to increase prices and costs. We believe this partially explains current cost developments.

In 1998 and 1999, both private payer and Medicare payment to cost ratios fell, encouraging hospitals to control costs in those years. This turned around in 2000 when private payments increased relative to cost. The decline in Medicare payment to cost ratio slowed in 2002 as well. This increase in the private sector payment to cost ratio reflects more aggressive negotiations by providers as well as shifts by payers and consumers to less intrusive forms of managed care. These changes have weakened the bargaining position of insurers in dealings with providers in general and hospitals in particular, which is conducive to more rapid cost growth.

I'll go briefly over some of the other factors we consider in our payment adequacy analysis. We discussed this last time. I'm refreshing you on it, but it's a secondary consideration.

First, hospital volume has been increasing at a steady pace after slow growth in the 1990s. Admissions increased a little over 2 percent in 2001 and Medicare discharges about 3 percent. Our study of entry and exit of

the industry shows that hospital closures have been continuing at a steady pace at pretty much the rate we observed in the 1990s which is continuous and minor. It's not having a great deal of effect. It's affecting mainly low occupancy hospitals and small facilities.

We also considered access to capital as an indicator of adequacy of Medicare payment. We presented some results last time and we heard some concerns. We've re-examined the findings we discussed last time and we've concluded based on more recent information that our conclusions were correct. We indicated then that based on developments in the bond markets and our observations of the stock market that the financial condition of the industry was judged to be healthy by Wall Street and that the hospital industry had adequate access to capital.

DR. ROWE: That's for profit?

MR. GREENE: On the stock market, of course, for-profit, but we're making a statement more broadly applying to the bond market and the capital access of non-profit facilities as well.

According to a new report by the credit rating agency Fitch, in 2002 there were fewer downgrades of hospital bond for every upgrade than in 2001. We examined information from Standard & Poor's last month and presented it. The Fitch report suggests that developments are not as positive as they were indicated to be by Standard & Poor's but the same general pattern prevails. 2000 is looking like a better year for non-profit hospitals seeking financing than 2001. More downgrades than upgrades, but nowhere near as bad as one would fear.

MR. HACKBARTH: Tim, on that issue, I recall reading in the text that if you just take a raw count of upgrades versus downgrades there would be more downgrades than upgrades, but if you look at the dollar volume there are more upgrades than downgrades. Did I understand that correctly?

MR. GREENE: I believe so.

DR. ROWE: The real issue is what proportion of the institutions are investment-grade and can access -- I mean, you could be a AAA-rated hospital and get a downgrade to AA and that's not nearly as important as a hospital that loses its investment-grade rating and doesn't have access.

MR. HACKBARTH: I think that's an important point. I recall also seeing some numbers on what proportion are

investment grade, although I can't remember the number off the top of my head. Do you have that in front of your, Tim?

MS. WILLIAMS: About 90 percent.

MR. HACKBARTH: About 90 percent are investment-grade. Maybe you can nail down that number for us. Why don't you go ahead, Tim?

MR. GREENE: Our second new piece of information is a report from Merrill Lynch. Merrill Lynch provides an overview of the hospital market, and in particular, the for-profit health care sector. Merrill Lynch sees the prospects for the for-profit sector as very good, and very bright in a variety of dimensions. It anticipates modest Medicare payment increase, but most strikingly, sees no slowing in private payment growth in the foreseeable future. They anticipate changes eventually but emphasize that in the foreseeable future we'll see continuing increased private payments, which is what we've seen in the last two years in the results we were reporting a moment ago.

In general, based on this information, and most importantly, on the overall margin information we discussed earlier we conclude that Medicare payments to hospitals are at least adequate.

Thank you. I'll be turning it over to Craig and coming back with an update recommendation later.

MR. HACKBARTH: While that's happening let me just try to set the stage for the process. There are a number of different recommendations under the general heading of hospitals, and as we've discussed at previous meetings, in a lot of ways they've related. We've talked to them as a package as opposed to just discrete units. So what we're going to do is have each of the presenters go through and describe the recommendations relevant for their piece, but we will not vote on recommendations until all of the hospital issues have been presented. Then we will have a series of votes both on each of the recommendations just one after another.

Again, one of the things that I want to underline here is that, certainly I individually conceive of these as a package. Although I think it's important for individual commissioners to have the opportunity to vote on each individual recommendation, I want everything on the table before we proceed to voting.

Craig?

MR. LISK: Good afternoon. This afternoon I'm

going to first discuss the IME adjustment and then Julian will accompany me and we'll discuss the expanded transfer policy.

In 2003, Medicare IME payments, indirect medical education payments will total about $5.1 billion according to the Congressional Budget Office, approximately 5 percent of Medicare inpatient payments. These payments go to about a quarter of Medicare PPS hospitals that train. Those are hospitals that train trade residents.

The IME adjustment is a percentage add-on to Medicare inpatient PPS rates. When the prospective payment system was established in 1983, the empirically derived estimate of IME was doubled. This doubling was achieved by reducing the base rates for all hospitals. The adjustment was doubled because preliminary analysis showed that teaching hospitals would perform poorly under the prospective payment system and doubling was a simple but arbitrary and quick way of dealing with this problem in terms of the analysis showing that teaching hospitals would not perform well. There was a lot of pressure at that point in time on Congress to pass the legislation implementing the PPS and this was the quick of dealing with that issue.

Some of the reasons for the poor performance though in that analysis is that teaching hospitals characteristically were poor reporters of case mix in terms of the early data. This is one reason. There was also some technical issues with how the empirical level was derived that may have also contributed to their poor financial performance in terms of the preliminary analysis.

However, once the prospective payment system was underway and implemented, teaching hospitals did not perform worse than other hospitals and performed -- actually had extraordinarily high margins in the early years of the prospective payment system.

Now the adjustment has been lowered over time and some key aspects of when it was lowered is it was first lowered with the implementation of the disproportionate share adjustment to help partially fund disproportionate share payments, and then again in the Balanced Budget Act. That proposal -- the Balanced Budget Act lowered the adjustment from 7.7 percent in 1997 to 5.5 percent in 2001.

Also it's important to note that the BBA provided IME payments for Medicare+Choice patients directly to the hospitals. So hospitals received directly those payments

whereas before they would have had to negotiate them with Medicare+Choice providers.

The BBRA and BIPA though stopped the phase-down from 7.7 percent to 6.5 percent and held the adjustment through fiscal year 2002 at 6.5 percent. In the current year we have just lowered the adjustment to 5.5 percent.

The IME adjustment is based on a formula which approximately raises Medicare payments for each case by about 5.5 percent for every 10 percent increment in the ratio of hospital's residents to beds. So a 400-bed hospital, for example, with 200 residents would get about a 25 percent increase in payments for each case above non-teaching hospitals, and a similar 400-bed hospital with 10 residents would get about a 5 percent increase in payments.

Now we have taken an analysis to measure what the empirical level of the indirect medical education adjustment would be. This is the measure of teaching hospitals' patient care costs relative to other hospitals and how much higher they might be. Our current estimate is the empirical level and we discussed it at the last meeting which, based on 1999 data, is 2.7 percent for every 10 percent increment in the resident-to-bed ratio. So the current payment is more than double what our current estimate of the empirical level is.

This estimate of the empirical level, in terms of analyses, has decreased over time and we discussed some of the reasons for the empirical level going down in the chapter.

It's also important to note though, and some people have raised this, is that any significant change in payment policies could affect the empirical level of the adjustment. But I want to emphasize that the impacts of a lot of those policies would be relatively small. They would not be of a huge magnitude to make a difference of saying that the current empirical level would change to being 55. percent, for instance, to the current level. Most of those changes would be relatively small.

Under the empirical level, if we consider that, IME payments in 2002 if we paid at the empirical level would be about $2.5 billion instead of the current $5.1 billion we estimate. So this means that IME payments above the empirical level total about $2.6 billion in 2003.

This next chart then shows for different levels of teaching intensity based on the resident-to-bed ratio, what

the IME adjustment currently is and what it is at the empirical level. To give you an idea of what this might mean on a per-case payment, if we have a case, typical -- on average, a standardized amount base payment rate is about $5,000 for a typical hospital and a typical case mix for a case of 1.5, let's say, so $7,500 for a non-teaching hospital. A hospital with 400 beds and 200 residents with a resident-to-bed ratio of 0.5 would receive $1,853 more for that case than a comparable non-teaching hospital. $983 of that amount is over and above what we would say the empirical level would be.

If you talk about a smaller teaching hospital in terms of a hospital with fewer beds, those numbers are much smaller. So a hospital with 40 residents and 400 beds would receive $400 more, approximately, than in non-teaching hospital because of the IME adjustment.

This next graph then shows under the current payment system the frequency distribution of teaching hospitals by their percentage increase in payments per case under the current IME adjustment. Almost half of teaching hospitals receive less than a 5 percent add-on to their per-case payment rates. That's the combination of the first two bars on the chart. About 10 percent of teaching hospitals receive more than a 25 percent adjustment add-on to their base rate. That's the hospitals with an IRB of greater than 0.5. For the extreme end, when we talk about at the very high end, 2 percent of hospitals receive an IME adjustment of over 35 percent. These hospitals have more than 75 residents per 100 beds.

I'm now going to show you two sets of margins, the Medicare inpatient margin and the overall margin to show the relative financial performance under Medicare for teaching hospitals. Again, as Jack had mentioned, there are the cost allocation issues when we present the inpatient margins; the inpatient margins are somewhat overstated relatively for all hospitals.

Major teaching hospitals are, in this graph, are hospitals with a resident-to-bed ratio of 0.25 or higher and they account for about one-quarter of teaching hospitals. Teaching hospitals do better with and without the IME payments above cost as we can see in this overhead. The first column shows what the margin would be if the IME adjustment was set in 2002 at 5.5 percent, we see that major teaching hospitals have an inpatient margin that would be

five times what that is for non-teaching hospitals. If we were paying at the empirical level the margin, of course, would drop for major teaching hospitals down to 13.8 percent, still substantially above the level for non-teaching hospitals.

As I said, this table provides the overall Medicare margin in providing the same context of the data for the overall Medicare margin, and again we see major teaching hospitals continue to have substantially higher margins that non-teaching hospitals, both with the current payment level and then if payments above the cost relationship were removed and we paid at the empirical level based on 2000 data.

So I want to next go to what the draft recommendation is. I'm going to present a little bit more information after presenting the draft recommendation here. The recommendation reads that the Congress should reduce the indirect medical education adjustment from 5.5 percent to 5 percent in fiscal year 2004 and gradually reduce the adjustment by 0.5 percentage points per year to the empirical relationship between teaching intensity and hospital costs per case.

In terms of the categories that we have for what the spending impact would be, it would decrease spending by $200 million to $600 million in the first year and it would be in the category of $5 billion to $10 billion over five years from 2004 to 2008.

So what would be the impact of reducing the IME adjustment from 5.5 percent to 5 percent on hospitals payments? Overall for major teaching hospitals, reducing the adjustment from 5.5 to 5 would reduce their payments by about 1.3 percent, inpatient payments by 1.3 percent and other teaching hospitals by 0.3 percent. You also see the impact on rural hospitals is very small, less than 0.05 percent.

Now some of the issues that have come up though with regard to issues of reducing the IME adjustment are that teaching hospitals have experienced a recent reduction in payments starting in fiscal year 2003. But keep in mind that we still show, even after accounting for those reductions we still show that teaching hospitals have substantially higher margins than other hospitals.

DR. ROWE: In 2003?

MR. LISK: Based on the 2000 data adjusted to

reflect the IME reduction.

Another factor that has been brought up is the total financial condition of teaching hospitals and at the last meeting we did show you that the total margins for major teaching hospitals were lower than for other hospitals. But as Jack had mentioned before, is that Medicare payment policies should not be driven by what is happening in terms of the total hospital margins.

So the issue is whether Medicare should consider what other payers do here, and generally it's been the policy of Medicare that Medicare pays for Medicare services. But we do have other missions is the other issue that comes up, and we have teaching hospitals that have research, uncompensated care and standby capacity are other missions that teaching hospitals have and that these revenues might be used for some of these other missions.

But to note that on research is we have NIH funding that is targeted towards that. On teaching, Medicare payments do pay for the higher cost of teaching hospitals and reflecting that in our payments for Medicare's share of those costs. On uncompensated care, I'll come to some information after that. And on standby capacity, if they have higher costs, we would be reflecting that in the IME adjustment -- that would be one of the factors that would be reflected in the IME adjustment, but also to reflect that certain standby costs are in certain DRGs and those DRG weights would reflect those higher costs.

So moving on to the uncompensated care. IME payments do not target uncompensated care burdens well. As we can see in this chart, we show uncompensated care costs as a percent of total hospital costs. This is AHA data for fiscal year 2000. We see that public major teaching hospitals have a substantial uncompensated care burden in terms of accounting for 20 percent of their cost. But private major teaching hospitals, which account for three-quarters of the major teaching hospitals, that share is just a little over 5 percent; a substantial difference. In fact that is below -- is about at what the national average is across all hospitals.

It's also important to point here too that teaching hospitals, in terms that we have another program in terms of Medicare is Medicare DSH payments and that teaching hospitals receive two-thirds of Medicare DSH payments of approximately $3 billion. Major teaching hospitals receive

$3 billion out of that $5 billion in Medicare DSH payments.

This next chart is also AHA data and this shows the distribution of major teaching hospitals in terms of the number of hospitals and their uncompensated care burden. We can see that the major teaching hospitals with less 2 percent of their costs for uncompensated care is the same number of hospitals that have an uncompensated care burden of 20 percent or more. And a substantial number that have very low -- that have the 2 to 5 percent range; it's also below average.

MR. HACKBARTH: Craig, is this one a combination of both the public and private --

MR. LISK: This is a combination of both the public and private, so we would expect that the public is more to the right side of this distribution here, but there is a distribution and it's a fairly wide distribution.

So the implication is that -- and is this true for all these different types of other missions that teaching hospitals may have, that hospitals' roles vary. Certain hospitals provide a lot of uncompensated care and others don't. The same with the research and teaching and standby capacity missions, those roles vary across the hospitals.

So with that I'd be happy to address any questions you may have and after that we can move on to the next presentation.

MR. MULLER: The question of the Medicare program bearing costs that are appropriate to Medicare and how it affects the margins is one I've raised before and I want to raise again. Both the IME and DSH program have been public policy for quite a while now, 15 years or more, reflecting the fact that Congress made a decision to allow Medicare to pay some costs that are not costs to the Medicare program, per se.

For example, it's easiest to point out in DSH but also point out in IME as well. In DSH essentially we put the total DSH payments into the hospital margins, yet we only put in roughly half the costs attributed to that because some of them are for Medicaid beneficiaries -- that's what DSH is for -- and we, of course, don't put the Medicaid beneficiary cost into the Medicare costs margins.

The same thing with IME, IME was intended to not just reflect the role that Medicare should pay of teaching but the fact that the teaching programs had a broad effect on society and therefore Medicare would pay for these even

when some other payers weren't covering it. So in both cases, DSH and IME, we overstate the margins by putting in the full revenue but not putting in the full costs, because the costs are outside the Medicare cost report.

If I use one of your tables that shows on DSH basically -- if you take your IME above cost out, the major teaching margins go down by about nine points. I think something roughly would happen, the same thing would happen if you took DSH out -- if you took some DSH out as well, if you follow my argument.

So insofar as we keep putting this red flag up there of these inpatient margins, especially in the major teaching hospitals, an awful lot of that would go away if you took what you call IME above cost, or I can say IME for other purposes besides Medicare, or the DSH payments that are covered in the Medicaid program. So a lot of that -- we reflect the margin, understandably so, because they are payments inside the Medicare program, but they're for costs that are not shown on the Medicare cost reports. Therefore we overstate the Medicare margin considerably inside this report and therefore we always cause ourselves to say, there's these enormous margins for major teaching hospitals.

But if you take the DSH, let's say half the DSH payments out, and take the IME payments above cost out, then the margins of major teaching hospitals go below the margins just inside Medicare inpatient by themselves. So I think we keep -- and I've raised this with Craig and Jack and others, that we keep overstating the inpatient margin considerably based on how we do our accounting. And most of that margin goes away.

I'd like to see what your numbers on it are but just looking at the IME above cost, nine of those 20 points go away, and my guess another nine of the 20 would go away with DSH. So you may have inpatient major teaching margins in the 3, 4 percent range on inpatient without that. So I think we should remember that the way we do our cost accounting dramatically overstates the margins on the inpatient program just the way the accounting is done.

I think secondly, the philosophical argument that Medicare should only pay for Medicare costs has been, in some sense, rebutted by what I just said. DSH is one, IME is another where in fact there have been public policies enacted by the Congress that essentially say they're going to pay, Medicare is going to pay for some costs that are

outside the Medicare program.

I agree with the majority of the Commission as expressed over these months that the Medicare program can't be stretched in too many purposes like that, and we had a discussion about that around freestanding SNFs this morning. But here is one that's been going on for 20 years or more. Some people could argue it goes back to 1966 in Medicare on the precursor to IME.

But I think we have had a public policy statement there that is contrary to the statement that you made, and I just would like to have that reflected, that Congress has reflected over the years that there are some costs the Medicare program will bear that go beyond the cost of Medicare beneficiaries. So by just saying as our paradigm that we'll only pay the costs that are in the Medicare cost report I do think we do misstate the public policy, and it's been there for a long time.

I'll get later into, I think why it's not appropriate to make these reductions at this time. You made some of the points in terms of the broader missions that the hospital is being asked to play, and the margins are going down. This is probably one place in which looking at total margins is somewhat relevant, and the total margins of teaching hospitals are well below the margins of other hospitals. Given the importance of the Medicare program to hospitals, looking at total margins as a way of helping to influence our understanding of the Medicare margin I think would be appropriate in this context.

But I do want to state, and I've tried to say this before that I think we consistently overstate these margins by the way in which we represent this data, by showing the full revenue but not showing the full cost. That therefore provides a red flag that causes people to want to say, margins are 20 percent -- high -- when in fact I think that consistently overstates those margins.

DR. REISCHAUER: Ralph, I can understand your logic with respect to DSH for which there is an explicit purpose, which is to provide resources for uncompensated care for the underpayment of Medicaid services or the extra cost that might be associated with treating low income or destitute populations. But I have a hard time understanding how the logic works with respect to excess payment for IME. Because there is no explicit purpose to which that money was directed. It was just like, we're very nervous that we

aren't going to pick the right number here so we're going to double it and then we work our way down.

MR. MULLER: No, one of the purposes of the original IME doubling, as Craig refers to it, if I can use that shorthand, was in fact to reflect this nervousness that the empirical calculation would not adequately capture the true cost of teaching hospitals. That's one of the reasons. That was not the sole reason.

Another reason was to look to have Medicare pay some of the cost of not being paid by the payers inside the program and to have that support inside the Medicare program. So we exclusively focus on one of those, but I think we should also acknowledge that there were other reasons for that.

MS. BURKE: At the risk of --

DR. REISCHAUER: Revealing how old you are?

[Laughter.]

MS. BURKE: Yes, revealing how old I am. Having sat at the table when this was all being discussed, it wasn't just a crap shoot. Admittedly, there was a great deal that we did at the time when we did the '83 bill and before that was not as refined as it might have been, but there was a broader conversation about the value of the presence of teaching in hospitals, and the value that that was to society and specifically to Medicare patients. We were concerned about, one, the overall impact on teaching hospitals of this new payment system that we were not sure about, which Ralph is absolutely correct about, and Craig is as well in terms that there was a doubling to try and capture what we really didn't yet know because we hadn't experienced it.

But there was a broader commitment that there was value in the quality of care and the kind of activity that occurred in an institution where students were present. So it wasn't simply, we don't know what's going to happen, it was really an investment in that activity. So it wasn't just we're going to do it because we're going to do it, it was really a commitment to those activities and the value that accrued to the Medicare patient by the presence of those activities in the institution.

So I think it more than simply, we don't know what's going to happen. It was also a fundamental commitment to an activity and Medicare's responsibility to help finance that activity because of the ultimate benefit

to the patient that was Medicare's as well as, frankly, as it was broadly in society in terms of the presence of teaching.

DR. REISCHAUER: But the question is, does that extend beyond what the empirical estimate of the cost is? That all I'm arguing.

MS. BURKE: I think it is -- at the time we clearly didn't know what that cost was. I think there is probably some debate yet today as to what really the empirical cost of that is. But it's not clear to me at the time that we were prepared to limit it only to that very narrow cost; i.e., the cost of a resident per bed. That it was really the broader commitment and the implications for those institutions of all of the things that they would incur by the presence of students. I'm not sure we knew then and yet today know how to capture all of that, what that really involves.

MR. HACKBARTH: The history is important and I consider Sheila an authoritative source on the history, but to me it doesn't seem decisive. Circumstances change all the time and if we followed the logic, Congress enacted this once, therefore we cannot consider it, our workload would go way down. I think the task that we're charged with is to take into account changing circumstances in the Medicare program and the health care system and make our best recommendations. Congress has the final say, of course. It feels too constrained to me to say, they intended this once and therefore we ought not take it up.

MR. MULLER: I don't think that's what I'm saying. What I'm saying is, however, narrowly defining the empirical level is the only thing that was ever intended and continues to be the only thing ever intended I think is too narrow an interpretation. Furthermore, as I've mentioned, putting the full revenues in and only put half the costs in, just by per se, makes the margins look a lot bigger. And as we've noted this morning and today, when the margins are up 10, 15, 20 percent, all of a sudden people say, that's a little bit too much. If these margins were two or three we wouldn't be talking about this.

I'm saying, if you took, as I have done, a number of those -- as least asterisk those margins, you would see those margins are nowhere near that. I think it's true on both DSH and IME. I referred to the IME for history and I fully agree that Sheila is the most authoritative source on

this, but it's been recognized over and over again by the fact that the payment has been well above the empirical level. So it wasn't just a one-time recognition.

DR. NEWHOUSE: I was going to make the same point Bob made, but let me amplify it in one way and raise another reason.

In terms of protecting the teaching hospital and how far back the policy went. The policy before the PPS paid costs which was, in this context, the empirical level. My recollection of that time was that there was no argument that teaching hospitals at that point needed additional protection. You were worried about what the PPS was going to do to the teaching hospitals. But that would suggest to me that there was possibly the intent was to protect the teaching hospitals to the degree they had been protected up to the point. That was point one.

Point two was the reason I asked about -- and I thank Alice for correcting me on accruals -- there's some work of Nancy Kane in a recent Brookings volume that suggests actually the margins are potentially quite misleading in that hospitals can -- and one should look at cash flow as a much more relevant indicator because -- the difference being that hospitals can take cash into or out of their accruals. And that in fact in her look at teaching hospitals, teaching hospitals had a more robust cash flow than one would have inferred from their margins on a small sample of teaching hospitals.

So I put that out there as a caution of putting -- casting all of this discussion in terms of the margins.

DR. WOLTER: Just a couple things. One is, are we so certain that the regression analysis has gotten to the right empirical relationship? And in that regard, the recommendation is fairly specific to reduce the percentage by 5.5 annually, although you might read the recommendation to allow for the target to change if more work were done on the regression analysis and we came to a different understanding of where we should end up. So maybe we should clarify that.

And then secondly, Dave Durenberger raised this at the last meeting, the timing of this is so critical, because although there is some breadth to the uncompensated care issue in terms of which institutions are affected than others, if this recommendation is adopted and some other approach to uncompensated care is not dealt with at least

roughly parallel it could be devastating to a subsegment of some very important institutions. I wonder how we would want to address that issue.

MR. HACKBARTH: So on the first point, Nick, if I understand you correctly, you would propose language to the effect that we ought to move towards the empirical level in equal steps so that if the empirical level were to change at some point in the future then the reductions change, either increase or decrease.

DR. WOLTER: I'm no expert on this but I understand that one of the arguments that people worried about this have is there may be some noise in the current target that we're at and perhaps there needs to be a little work done on what really is the cost of providing teaching, and maybe 2.7 percent ultimately won't be the target that we get to.

DR. NEWHOUSE: Can you say what you think the problem is? As far as I understand it, this is the same method we've always used, so if the original number was the right number, this is the comparable number now.

DR. WOLTER: You probably know much more about this than I do, Joe, but I think there are many people worried that this doesn't capture entirely the cost of teaching and the cost of educating post-medical graduates. I'm saying, we're making a recommendation now that spreads itself out over three or four years based on 1999 information. And that as more work is done on this, if there is some adjustment in the target, do we want to make sure that we have the flexibility in this recommendation to be sure that that's accommodated.

MR. SMITH: Both Nick and Ralph have raised questions about getting the numbers right. It seems to me it's important to get a third number right here. I'm struck, Craig, that we didn't come back to -- although you did in the text, but didn't come back with one of the dramatic charts to the total margin data for hospitals across the distribution.

If we're buying public goods, whatever those public goods are, IME, uncompensated care, support for the research establishment, we're buying public goods then the right thing to look at to assess the capacity of institutions to provide those public goods is total margin not Medicare margin. Medicare is contributing to it and there is a policy question that Congress has addressed with

the clear answer, if not always the right numbers but a clear answer that, yes, Medicare ought to be in the business of helping support the purchase of public goods.

We might not have invented this scheme if we'd sat down with an empty piece of paper, but it's the scheme we have. And we have chosen to use this payment system to contribute to the purchase of things that we believe have broad social value.

I think for those reasons alone, it seems to me, we ought to be very nervous about cutting into the capacity of a group of institutions that are especially capable of and especially burdened with the responsibility of providing those public goods. So we ought to remember when we looked at the total margin data for large teaching hospitals they were at the other end of the distribution, unlike when we simply look at the Medicare inpatient margin.

DR. ROWE: Thank you, Glenn. We've all been thinking about this issue for a long time, both together in this forum and other forums and I've recently come to a different view of how we should approach this which I have mentioned to a couple of my colleagues, some on the Commission and some not, and gotten encouraging responses. I've not spoken with any of the organizations in the environments so I don't have the benefit of their input, although we may get that later.

But I'd like to take a minute and propose a different way of looking at this. I'll try not to repeat anything that's been said although I associate myself with many of the comments. The only thing I would repeat is Bob's comment about, a concern about no explicit purpose for the subsidy. I don't like it either. I'm offended by it. We're just throwing the money at the hospitals. They can use it for advertising, they can -- there are no costs that it's lined up against other than these general social goods, et cetera. I'm not against Medicare supporting it, but I think it would be better to have a more explicit purpose.

But I believe we should approach this by looking forward, not looking back. I think we are making this policy looking in our rearview mirror. I believe there are very, very substantial data to support the view that teaching hospitals are faced with very significant challenges to strengthen and modernize and reorient their clinical educational capacity. That this has to get done with significant investment in information systems, in new

curriculum, in preparing students for lifelong learning, and interdisciplinary approaches with physicians, nurses, and others being trained together in teams, et cetera.

They spend a lot of time in a variety of forums studying this. There are great needs and some institutions are doing it, but many aren't. To prepare themselves for the future demands of the health care system and the Medicare beneficiaries they need to do it.

I think that many of institutions we're talking about don't have the resources either in terms of access to capital or margins to do it. What I would favor is a proposal in which we take the excess over the empirical level and we identify that as funds to specifically be used to support the modernization and the information systems infrastructure, et cetera, of the medical education capacity of teaching hospitals, and we establish criteria for that and they demonstrate that they meet them in order to qualify for the funds. And if they don't meet them, they don't qualify for the funds.

And we use these funds not as a political hedge for the general social well-being but as a direct stimulus to help these institutions align themselves with the needs of education of the modern medical workforce. So I would propose that rather than the proposal that we have, with all due respect to the staff, that I would propose that an approach to developing criteria over a very short period of time and requiring that hospitals meet it, and if they don't meet it within 24 months or show tangible progress then we go into this reproduction phase.

So that's an alternative strategy that I think looks forward rather than back. I'm interested, obviously, in my colleagues' response to this.

DR. STOWERS: I was going to get back more to what Nick was saying. I think if we are going to have a variable target in here, we ought to have some kind of a variable progression down to the empirical rate rather than just blocking off 0.5 a year times whatever, because it's not obviously going to come out even as we do that.

Then you talk to the five years. I can see the five years maybe being a time to allow the academic medical centers or whatever to adjust for the decreasing revenue over time, but I think another factor in there is how long is it going to take us or Medicare or Congress to correct the uncompensated issue which we see some of the academic

medical centers doing a great deal of and others not doing a lot.

So I think I still, and I've said it before, I think that we have to tie those two together. So if we're going to have a commitment to bring this down to the empirical level over a period of time then we need to have the uncompensated thing. So if that can be done on a five-year schedule then the five year thing makes more sense. But if that's going to take 10, whatever -- or maybe it will take less.

MR. HACKBARTH: I'd like to make just a quick comment on what Jack said. I'm with you on the premise. As you know, my concern about these payments has been that it's a lot of money at a time where we know that Medicare faces both immediate fiscal pressures and certainly long-term pressures, and I'm not sure that we can afford the luxury of paying such a large amount of money without very specific purposes in mind and being confident that we're getting value for our money, so to speak. So I start in much the same place as you, Jack.

I guess the questions that I have about your alternative are two. One, as you presented it it seems to assume that we're still talking about Medicare trust fund dollars. And a second reservation that I've had about this policy is using trust fund dollars, the money raised by a payroll tax, for these broad public purposes. I'm not sure that that's the proper financing mechanism.

Now having said that, I understand the institutional reasons in Congress for that approach, but it does make me a little bit queasy to use payroll tax revenues for these broad social purposes.

The other question that I have is, if I understood you correctly, it sounds like only teaching hospitals would be eligible for these additional payments. There are a lot of hospitals that face critical issues, for example, with information systems, which I think is a really pressing problem for the health care system and an important impediment to improving the quality and safety of the care we provide. To say we're going to put aside $2.5 billion, and by the way, it's only teaching hospitals that are eligible, again, makes me a little bit uneasy.

DR. ROWE: I can respond to the second question. The first concern I think is an interesting policy issue we're probably not going to solve here today.

What I had in mind -- this is an idea and, again, I'm interested in other people's reactions -- was I was focusing on the E part of IME. I would expect, in fact predict, that such investments would improve the quality of care, and we could use some of that. It may even improve the efficiency of the care. But I was focusing on the E part as the essential thing that needed to be -- that the idea of these changes would be to improve the educational process, which I think is broken and becoming archaic in many institutions. These funds were initially identified for educational purposes so that was what I had in mind. So I'd give them to the teaching hospitals but I would predict benefits in quality of care, cost efficiency, et cetera.

MR. HACKBARTH: I have Joe, Allen, Bob, David, and then I think we need to move on. As important as this is, we've got a lot of ground to cover.

DR. NEWHOUSE: I originally wanted to respond to David but I also want to say something about Jack's epiphany.

[Laughter.]

DR. NEWHOUSE: I don't think of these payments as buying a public good in the strict sense of a public good, meaning something that we all consumer like national defense, and one person's consumption doesn't reduce another's. I think of this, the extra payments to teaching hospitals as we're paying for the extra cost of patient care at the teaching hospitals. That's a product we've said we want to pay for, and I have no problem in paying for it, but that gets you to the empirical level.

Another way to say that is, had we not put these extra payments in, and had we paid the average cost per case across all hospitals, teaching hospitals would have taken it in the neck and would have gone out of business if everything had been Medicare and they hadn't been able to offset it in other ways, and so forth and so on.

So it's perfectly legitimate to have extra payments for teaching hospitals without going to what in my mind is an additional and probably wrong place to be of the saying that these extra payments are buying a public good. They're coming from the cost reports that teaching hospitals write down on their costs and those costs are basically buying, I think for the most part, a more intensive style of care for a given patient at that hospital. That's fine.

Then that also goes to the point the point that both Jack and Bob and others, and I've raised, that it's not necessarily paying for a medical education mission.

Now that being said, if we are going to have these payments I can see a good rationale for Jack's suggestion. One of the common complaints about traditional Medicare from lots of quarters is that we have a quality problem and traditional Medicare is a big part of the problem, and it doesn't really do anything to address quality of care even though the way this is set up it is limited to teaching hospitals. I sympathize with Glenn's objection here.

In effect, conditioning the subsidy on some measures like adopting information systems would have the effect of having Medicare get closer to the vanguard of trying to do something about the quality chasm. So if we're going to have this subsidy I think I'm in favor of conditioning it in the way Jack suggests.

MR. FEEZOR: Actually, Joe took some of my comments. I haven't had many epiphanies but I would strongly associate mine with Jack. In California we're trying -- we know we can't come up with any additional dollars so what we're trying to do is, can we get better results and a different set of dynamics with the dollars we are spending? I think Joe is right on target. There are very few times that Medicare can do that. We seem to be, as you said, driving in our rearview mirror.

I think if those dollars are going to be spent, demanding accountability that would make some changes, that would emphasize both quality, effectiveness, and efficiency I think would be a very worthy cause, so I'd like for us to consider some language around those lines.

DR. REISCHAUER: Comments on comments. With respect to Nick's point, I think the recommendation says that we're just going to go to the level that the empirical evidence suggests. So you really don't have to worry that a change in that estimate because of better analysis, new data, whatever, is going to cause a problem.

The real question that's relevant, it strikes me is, is 0.5 in one year too big a fish to swallow? Should it be 0.3? Should it be 0.7? Who knows? But if there was a sudden surge of analysis that showed the appropriate payment level was really 4.8 percent rather than 2.7 we'd go down 0.5 in one year and 0.2 in the next year and then just stop. So I don't think that's something that we should be

concerned about.

With respect to David's point, taking Joe's amendment that these aren't publics, they're really social goods, and hospitals, many hospitals of all kind provide these. Teaching hospitals might provide more than others but it certainly has to be an extremely bizarre way to distribute money for providing social goods, to distribute it based on the ratio of residents to beds and the number of Medicare patients that you serve. You've got to ask yourself, what is it that they're doing and let's pay them for what they're doing.

With respect to Jack's point, I guess I can swallow hard and overlook the trust fund source of payment and focus on the education role. But I really think this is a huge issue and what we really should do is spend some time thinking about exactly what kind of leadership role do we want these institutions to provide. Somehow I think that this is a recommendation that is not going to be adopted by Congress within the next couple of weeks and we might be here next year having the same discussion, at which point we would have the time to think about a more careful definition of exactly what it is that this money should be devoted to and how one would design the incentives and the procedures and the eligibility, whether it would extend beyond teaching hospitals or not.

DR. ROWE: More detailed. I was careful; just imprecise.

MR. HACKBARTH: Of course related to that is also, what is the right amount for this additional purpose? Is it, just by coincidence, $2.6 billion, or is it some other amount? I have David and then I'd really like to move ahead, Ralph, if we can.

MR. MULLER: I'll be very brief.

MR. HACKBARTH: Maybe even briefer than you realize.

[Laughter.]

MR. SMITH: To Joe and Bob, I thought I said social goods. You're absolutely right, these are things that we value. They aren't public goods the way economists think about them.

If I understand Jack right, and as usual Jack's epiphanies are provocative, what he's proposing, and I support it, is that we increase the empirical level. That we devote more resources to the teaching mission, that we

get more sophisticated, that we improve both the quality of the inputs and the share of resources that we devote to it. I think that's right. I don't know what the right number is, whether it's 2.8 or 3.5.

But the question that we're being asked to deal with in this recommendation is not whether or not the empirical level is right, but whether or not the subsidy, in addition to the empirical level, should be retained. I don't think Jack's question or Jack's proposal addresses that.

The arguments that Nick and Allen and I tried to make didn't speak to the question of whether we are appropriately investing in the educational mission. I'm quite sure Jack's right, and to the extent that he wants to propose increasing it I think we should take that very seriously.

But that's not an argument that says that we ought to arbitrarily -- and, Bob, you're right, it's a bizarre formula. But it is the formula that we have. We are where we at the moment and we are buying something that Congress has regularly considered that it wants us to purchase. Either the proposal before us or Jack's modification would result in a recommendation from this commission that we stop buying those social goods. I think we shouldn't make such a recommendation and when the time comes I'll oppose it.

MR. MULLER: This goes to both Bob's and David's and other point, is we keep talking about the empirical level, and certain in these 19 years since PPS we have used the resident ration as a way of allocating the payments that are under the broad definition of IME. That, as I said earlier, and Sheila being present at the creation affirmed, that wasn't the only purpose for which the IME payments were intended.

We use the resident ratio -- I grant with Bob it's not -- it seems to be the measure that we have and have used for 19 years, and people have tried to come up with other ones. But it's not the only purpose for which IME was intended; the support of residents and just the indirect costs that come from having residents inside a hospital.

So I want to second David's point that the subsidy above this so-called empirical level is in fact something that we should support and have supported. The fact that we have only this resident ratio as the one by which we've been distributing these payments over these 20 years doesn't mean

that's the only purpose for which this payment is intended.

DR. NELSON: If I'm going to vote against the recommendation -- and I haven't spoken and I've been trying to get recognized -- I ought to have an opportunity --

MR. HACKBARTH: I'm truly sorry.

DR. NELSON: I ought to have an opportunity to say why I'm going to vote against the recommendation.

My concerns have to do with reducing the payments to the teaching hospitals from 6.5 to 5.5 percent, and reducing it further when we haven't seen the impact of the earlier reduction from 6.5 to 5.5 percent, with no understanding of within that very small Medicare margin, whether that's a bimodal curve with one population of major teaching hospitals that's doing very well and another population that may go belly up as a result of this cut.

So my concern is with making a further reduction in IME payments when we haven't seen the impact of the current reduction that we're only three months into, given the uncertain circumstances and my inability to know how big of a problem that's going to cause for how many large teaching institutions.

MR. HACKBARTH: I'm sorry, Alan, I didn't see your hand. Have I missed anybody else? I really don't want to prematurely cut off, but I do feel like we need to move on here.

If there's nothing else, here's where I think we stand in terms of process. We have the draft recommendation on the table and I'd like to vote on that. Not right this minute but when we get to the end of the whole package. Then, Jack, I have a question for you on whether you want to offer, after that vote, the Rowe proposal? If so, I'm going to put the heat on you to come up with some specific language so that we've got something in front of us.

DR. ROWE: Given any encouragement, I'd be happy to do that.

MS. DePARLE: I hope you will. Some of use haven't spoken, but I like that proposal I'd like the chance to address it.

MS. RAPHAEL: One clarification. At the end of this we're going to integrate all of these and get the full impacts, aren't we, before we vote?

MR. HACKBARTH: Yes, there actually will be some impact analysis that shows you the effect of all of it together, which again will underline the fact that we've

talked about these as piece of a whole as opposed to discrete proposals. But we'll do that at the end, Carol.

So what I hear, Jack, is some interest in your putting pen to paper, so go ahead and start writing.

For the time being, we will move on from teaching to the expanded transfer policy.

MR. PETTENGILL: At the December meeting Craig presented information about the so-called expanded transfer policy in the hospital inpatient prospective payment system, and the rationale for and the effects of expanding that policy to additional DRGs.

In a subsequent discussion you raised some important concerns about the policy's impact on hospitals and patients, and just to refresh your memory I thought it would be useful to identify what those concerns were.

One was that extending the policy would undermine the averaging principle that is central to the prospective payment system. Another was that it would penalize hospitals that improve efficiency. A third was that it would create incentives to discharge patients to home without post-acute care or to extend their inpatient stays. Another was that it would disproportionately affect hospitals located in regions that have relatively short length of stay patterns because they would be more likely to trigger the policy with short stay transfers to post-acute care.

Finally, some people argued that we don't really need to do this because most patients discharged to post-acute care have relatively long stays, and second, because Medicare has hardly switched its payment methods for most post-acute care providers from cost reimbursement to prospective payment, thereby presumably vitiating the incentives to transfer people.

In this session we're going to review the rationale for the policy quickly, and the evidence, and then present a draft recommendation. Along the way we'll try as best we can to address the concerns that were raised at the last meeting.

For the benefit of commissioners and members of the audience who were not here at the December meeting or missed that discussion I'd like to begin with a brief review of the origins of the transfer policy and a little bit about how it works, and then I'll talk about the rationale for extending it, and the flip side, which of course is, what

are the implications of not extending it?

Then Craig will present some data, which is mostly new, that we hope will help you to decide whether it would be desirable to extend the policy to additional DRGs, and if so, how rapidly that extension should occur.

So let's begin with the origins of the transfer policy. I want to start by saying that the transfer policy has always been a part of a larger design, as part of the payment system, for dealing appropriately with factors that might change the service content and the cost of care over time.

The initial DRG payment rates reflected the historical cost of the service bundles associated with the DRGs in the base year of the prospective payment system. But hospitals facing fixed price payment have very strong incentives to reduce their costs, and they can go about doing it in a number of different ways. One of them, for example, is to adopt process improvements and new technologies that improve productivity and reduce costs. Another is to shift services to another setting, either at the front end of the stay or at the tail end of the stay. A third is simply to stint on care and provide fewer services.

Now policymakers at the dawn of all this recognized that the prospective payment system would have to have policies to address these kinds of changes. The most obvious processes or policies in place are the annual processes we use to update the base payment rate and to recalibrate the DRG weights and the wage index, and so forth. Those policies are appropriate vehicles for dealing with changes in technology and practice patterns that affect the cost of care in a DRG, broadly within a DRG or across all DRGs and hospitals where you have essentially the same phenomenon, reductions in costs going on widely. In fact MedPAC, and ProPAC before it, and CMS have all had site of care substitution factors in their update frameworks for many years.

The site of care substitution component was intended to reduce the update when hospitals were decreasing their costs by discharging patients to post-acute care, thereby shortening their inpatient lengths of stay and providing fewer services then were implied by the DRG payment.

In addition, the prospective payment system has always had policies designed to reduce the financial rewards

that providers could earn by unbundling care to other settings. For example, the 72-hour rule says that if a hospital provides in the outpatient setting related services within three days prior to an admission, those services are part of the stay and can't be separately billed.

At the tail end -- and here the transfer policy applies, originally it applied only to discharges to other PPS hospitals after a short stay where, arguably, the transferring hospital was not furnishing the same product as for cases that were kept in the same DRG till discharge.

In the BBA, Congress extended the policy to cases discharged to post-acute settings after relatively short stays out of essentially the same concern, that providers were not furnishing the same product in these instances. This policy was implemented for the initial 10 DRGs beginning in 1999. The Secretary was authorized, but not required, to expand the policy to additional DRGs, and in the proposed rule for fiscal year 2003, this year, the Secretary considered expanding the policy to an additional 13 DRGs and to all DRGs. But facing substantial pressure from the industry, the Secretary was not prepared to go forward at this time without reviewing all of the concerns that were raise in comments to the proposal.

Now a little bit about how the post-acute care policy works. First, it applies only for cases that are discharged to PPS-exempt hospitals such as rehabilitation hospitals and units, psychiatric hospitals and units, or long-term care hospitals, or to skilled nursing facilities. It also applies if a patient is discharged with a plan of care to related home health care that begins within three days after discharge.

Transfer cases are paid a per diem payment rate for each day up to the full DRG rate, and that per diem is simply the regular DRG payment rate for the case divided by the national geometric mean length of stay for the DRG. So a hospital in a DRG that has a payment rate of $5,000 and a geometric mean length of stay of five days, the per diem payment would be $1,000. The payment is a graduated payment. It's doubled for the first day, to reflect the fact that in almost all DRGs, the most expensive day is the first day, and that's followed by less expensive days as you go further out in the stay. So the hospital would receive $2,000 for the first day and $1,000 a day for each subsequent day up to the full DRG rate, which would be

achieved at day four. That is, one day below the geometric band length of stay.

As we noted in the mailing, in some surgical DRGs where you have very high costs in the first day, more than half the cost is incurred in the first day, there's a modified method in which the hospital receives half of the full DRG rate plus a per diem payment, and then half a per diem payment for each subsequent day. Of course, in this case they still reach the full DRG payment one day before the geometric mean length of stay.

I'd now like to turn to the rationale for extending the policy to additional DRGs.

MR. HACKBARTH: Julian, can I interrupt for just a second? I just want to make sure that we're using our time effectively. Do people feel like we're going over things that they're very familiar with in terms of the mechanics of it and the rationale? If so, maybe it would be good, Julian, to skip ahead a little bit in your presentation so that we can maximize the amount of time we have for discussion.

MR. PETTENGILL: Okay. All I was going to say here is that there are basically three reasons to do it. One is that you want to recognize that hospitals, when they transfer patients to post-acute care, are not providing the same product. Now that may not be true 100 percent of time. There may be individual cases where they are in fact providing the same care that someone would get if they were discharged to home the same day. But it's true a portion of the time.

Another reason is to promote payment equity by targeting the reduction in payments to the cases where a different product is actually being provided, and not to all hospitals. A third reason is to create a better balance between the financial rewards of transferring patients and the clinical reasons for doing so.

You might well ask why the normal update process can't be used successfully. The answer to that is on the next slide, and it's basically that site of care substitution isn't uniform. It's concentrated in some DRGs much more than others, and it's concentrated across hospitals, as some data that Craig will show you, will demonstrate. The annual update and recalibration processes essentially treat all cases the same way, so they would reduce payments to all -- to the extent that transferring is

occurring, they would reduce payments for all cases.

In fact in DRGs where there's heavy use of post-acute care, it would reduce the DRG weights because the short-stay cases that are low cost cases are being counted as full cases just like any other and it brings the average down. So what you'd be doing, if you don't extend it, is underpaying cases that are not transferred relative to those that are.

Now Craig will present some data that we hope will help you to make a decision here.

MR. LISK: I'm going to start out with some evidence of substitution over the past decade. First, we have seen Medicare inpatient length of stay drop by 35 percent, which is greater than what has been experienced by the private sector. At the same time, the proportion of cases discharged to post-acute care increased substantially by -- increased 49 percent. In 2001, 30.5 percent of cases were discharged to post-acute care settings. The increase since the beginning of PPS is even much greater than these numbers imply.

We can interpret this data in two ways. One, all the growth in post-acute care was new care and the length of stay declines observed would have happened anyway. Or some part of the increase in post-acute care use represents substitution from the inpatient setting and contributed to some of the declines in length of stay. The latter, we believe, seems more plausible. Some other information that corroborates that is some of the other supporting evidence includes greater length of stay declines in DRGs with high use of post-acute care compared to other DRGs, and greater length of stay declines for post-acute care users compared to non-users. There's evidence of that substitution.

This next slide shows the length of stay distribution for DRG 14 which is for strokes, one of the 10 current DRGs affected by the post-acute transfer policy. There are about 300,000 cases in this DRG with a little more than half the cases being discharged to post-acute care. Cases discharged to post-acute care with length of stay from one to three days would have payments reduced under the current transfer policy, and hospitals receive full payment at four days and longer.

We're showing you this and another chart, but we observed this pattern in terms of length of stay pattern is typical across DRGs of post-acute care users and non-users.

So what we observe is that transfer cases tend to have longer stays and fewer shorter stay cases. The shorter stay cases are generally less common.

So here we have the same information for DRG 79, which is for respiratory infections, one of the 13 DRGs that was being considered for expansion. Again in this DRG, cases staying one to five days would have their payments reduced under the transfer policy. Again, the picture is similar to the previous chart and is pretty consistent across DRGs.

I also wanted to bring up one other point. Some have argued that we do not need post-acute transfer policy because these cases have longer stays. But in fact some do have shorter stay, as we showed. Yes, they are less common than for non-transfer cases but there are many cases that do have -- that go on to post-acute care that do have shorter stays.

We would suspect that the distribution would shift somewhat to the right, if we asked the question of, what would happen to these cases if there was no post-acute care provided? We would suspect if there's some substitution going on that they would have stayed a little bit longer in the hospital and the distribution would have shifted some to the right.

DR. MILLER: Craig, can I interrupt for just one second? We're looking ahead and also looking at the time. I notice that we have a lot of charts for different kinds of DRGs. Is there a way to move through this and to make your point with one DRG and move past --

MR. LISK: We're using just one DRG here. There's several slides that show the different relationship of payment to cost ratios and we can go through those pretty quickly.

This next slide we group hospitals by the percent of cases discharge to post-acute care, which is shown in the first column. The second column shows how they are distributed with 10 percent of hospitals discharged less than 10 percent and other Medicare cases going to post-acute care, and 4 percent at the bottom, discharging more than 50 percent of their cases.

As we can see, hospitals vary in their proportion of cases discharged to post-acute care. This is consistent across DRGs. Those with high rates of post-acute care use consistently have higher use rates across DRGs, and those

with low rates of post-acute care use consistently have lower use of post-acute across DRGs. These findings hold whether the DRG has a high rate of post-acute care use, like DRG 209, which is for hip replacements, or DRG 116, which is for pacemaker implants.

This next slide shows the payment to cost ratio for transfer cases before and after the transfer policy. The red line shows the ratio before the transfer policy and the green dotted line shows the payment to cost ratio for transfer cases under the policy. Now we're showing just one example but the findings are very similar across all DRGs that we have examined. We examined for all 13 DRGs considered under the expanded, and additional DRGs as well. But this relationship is very similar.

The chart shows the rewards for discharging patients early without post-acute care transfer policy is very large. But even after applying the policy we are still paying substantially above the cost of care, just the size of the reward for discharging early is diminished under the expanded transfer policy.

These very high payment to cost ratios may imply that the cases are not getting necessarily the full complement of care implied by the average payment for the DRG.

This next slide shows how the distribution would change if we consider all other cases, and what we see is actually across the full length of stay and we see that the distribution drops just slightly. The basic averaging principles of the PPS though still hold. Now some have argued that the transfer policy violates the principles of PPS averaging. However, the old average implied by a full DRG payment is no longer the correct average if some of care has moved from the hospital to another setting. The transfer policy, rather than reducing payments across all cases, the policy reduces payments for cases where the substitution likely occurred. That is cases discharged to post-acute care with short stays.

Another interesting finding though that we find is this next slide that shows payment to cost ratios for post-acute care users and non-users. What we find in this slide, the red line is for post-acute care users is higher than for non-users. Meaning that the post-acute care users for the short stays have lower costs than other cases, meaning they may not be getting necessarily as many services as implied

by the full DRG rate. This is a consistent pattern across DRGs. This may also imply, again, substitution is going on for these cases.

DR. NEWHOUSE: I don't understand actual to expected length of stay. What does expected length of stay mean?

MR. LISK: Expected length of stay is, given your case mix, what you would -- if you stayed the average for the DRG, what your length of stay would be. So if you have an expected length of stay that is lower, you are staying less than average.

In this next slide we group cases by the proportion of cases discharged to post-acute care with short stays. In other words, the percent of Medicare cases that would be affected by the post-acute care transfer policy. The second column again shows the distribution of cases.

No motivation for this table was to show how hospital's financial performance might be related to the percentage of cases hospitals discharge to post-acute care after a shorter than average hospital stay. We find that hospitals with a larger proportion of short stay transfer cases have higher Medicare inpatient margins, and these margins are without DSH and IME above cost, reflecting the margins for the base rates.

What contributes to this better financial performance? Hospitals that discharge a large proportion of cases to post-acute care with short stays have length of stays that are lower than expected given their mix of cases. The lower length of stay is a good thing and one factor that contributes to their better financial performance. They also discharge a greater proportion of cases to post-acute care as well, and the combination of these factors may be what's contributing to their lower length of stay and their better financial performance.

But this brings up another concern that was raised at the last Commission meeting, that the transfer policy might penalize hospitals and regions with short stays. As the table above shows, length of stays varies by regions, although the differences are not as great as they used to be.

If we compare average length of stay with the percent of cases discharged to post-acute care settings with short stays we do see an inverse relationship. Hospitals and regions with shorter average length of stays tend to

have a greater fraction of cases discharged to post-acute care with short stays, the second column in the table. That's post-acute care cases, how many are discharged with short stays.

But that one column does not drive what the effect of the impact of the transfer policy. The percentage of cases affected by the policy is a product of two components. First, what proportion of cases you discharge to post-acute care and then how many of those have short stays. So the net effect is not as great when you combine the two effects.

It's also important to remember that the PPS is a national payment system so we don't have policies that vary other than the wage index that vary by hospital's local circumstances. And the hospitals with shorter average stays benefit for all their other -- should benefit for all their other cases that have shorter than average lengths of stay.

DR. MILLER: So, Craig, the point here in this chart is that -- the specific question last time was a concern that length of stay varied across the country and that this policy would essentially be penalizing people just for having short lengths of stay.

MR. LISK: That's correct.

DR. MILLER: And what this shows is actually the intervening variable that is relevant here is what proportion of cases are sent to post-acute care, transfers, and then the relationship between regional length of stay and the impact of the policy is no longer clear. It's much more just a random --

MR. LISK: Yes, it's less clear.

DR. MILLER: That's what I think the point of the slide is.

MR. LISK: The next two slides I'll show will show the payment impacts of expanding the policy to all DRGs. As we see here, it's related to the percentage of cases discharged to post-acute care, with larger impacts on hospitals that discharge a greater proportion of their cases.

We show here both the impacts for the initial -- for the 13 DRGs and the impacts of expanding to all DRGs. The impact across hospital groups is fairly uniform. You have that table in your report so I'm not going to show you that here today.

Now these impacts are based on modeling of the 2001 claims data. You may see slightly different results

from Jack's presentation when we factor this into -- in terms of the total impact when you factor this into 2003 payment policies. The total impacts are a slight bit lower, 0.3 and 1.1 percent overall from going to a full expanded from those two numbers.

Then finally this next table shows really what is the undiluted impacts of the policy with the proportion of cases affected by the policy. We see that the impacts are much greater on hospitals that discharge a high proportion of cases to post-acute care with short sure stay. Under 13 DRGs, those that discharge more than 15 percent of their cases with short stays to post-acute care is -1.1 percent under 13 DRGs, and under all DRGs is -3.8 percent. This policy basically targets hospitals with the greatest amount of site of care substitution in terms of the focus.

So this leaves us with the recommendations. We have two options here. The first one is, that the Secretary should add 13 DRGs to the post-acute transfer policy in fiscal year 2004 as part of a three-year phase-in. It expands the policy to all DRGs.

In terms of the buckets that we have for the impacts, this would be in the category of $200 million to $600 million over one year, and the five-year impact would be in the category of $1 billion to $5 billion.

The alternative recommendation B is that the Secretary should add 13 DRGs to the post-acute care policy in 2004 and then evaluate the impact before proposing further expansions.

The one-year impact of this policy would also be in the $200 million to $600 million category and the five-year impact would be in the $1 billion to $5 billion category as well, but at the lower end of that category compared to the first.

DR. STOWERS: Craig, obviously you were not talking about doing this budget neutral. This was originally presented to us to help better distribute funds between those hospitals across the country that may have availability of post-acute care and those that might not. That was the premise that we started on. If in fact we were really trying to fulfill that premise, wouldn't this be budget neutral rather than otherwise? I'm just asking that question on the budget neutrality because it's come up several times already.

MR. LISK: I think you have to think about that in

the context of all the recommendations you're considering today.

MR. HACKBARTH: Let me just pick up on that point. If you were to apply that concept here you would need to apply it, I think logically, in some other places in the package as well. For example, the change in the base rate, and going to a single base rate as opposed to a differential for the rural and other urban.

Unfortunately, I have a piece of paper that you don't have but you can piece it all together. But the bottom line is that if you applied this budget neutrality concept to transfer policy and the single standardized amount, basically they offset each other in terms of the net budget impact. And I think you'd have to do it for both of them, so you end up at zero. One is a plus 0.3 and the other is a -0.3. So in terms of our aggregate budgetary impact you end up at the same place.

DR. STOWERS: The package concept.

MR. HACKBARTH: Right.

DR. WOLTER: Is that if we expand the 13 DRGs or to all DRGs?

MR. HACKBARTH: That is the 13.

MR. DURENBERGER: Question about what information we have about what I'd call discharging up as opposed to discharging down. In other words, a lot of rural or smaller hospitals frequently on admission find complications that they can't handle in a patient and they will discharge to a tertiary care hospital in some larger community and so forth. Are there certain presumptions about all of this that are based on both kinds of discharges?

DR. NEWHOUSE: This is all independent of that. That just continues as it's always been.

DR. WOLTER: I want to thank both of you for trying to address many of the questions asked last time. I still have a few.

When you say that looking at how marginal costs are covered extends to DRGs to which the transfer policy would apply, that still remains a little bit vague and there's really no sources cited in the paper and that has been said several times; have we looked at all 500 DRGs? Have we looked at the additional 13? Have we looked at a random sampling of those beyond the 13?

MR. LISK: We have looked at all 13 DRGs that are included plus a random sampling of other DRGs that both have

high post-acute care use and actually low post-acute care use, and our findings are consistent across DRGs. Then you have the cases where you do have some cases where the payment to cost ratio is below one when you put in the transfer policy, the basic transfer policy, but when you do the modified payment that Julian described, their payment to cost ratio then goes well above one in those circumstances. But this is consistent across all the 13 DRGs we examined plus a random sample of other DRGs.

DR. WOLTER: I think this is an important question, at least for those of us in this business because I think we believe that there is a universe of DRGs where there's a pretty good margin and there's a universe of DRGs where almost always there's a negative margin. I think in particular their proposal to extend transfer policy to all DRGs has many of us questioning what that will do to margins.

I would also say that I didn't quite understand the argument that because there are still a number of short transfer cases that we shouldn't be concerned that, I think it's some 72 percent on average within a given DRG where there's a short stay transfer are actually transferred at length of stays beyond the mean geometric length of stay. So I think a number of us are concerned about this will all work out over time, particularly with changes in the last few years where length of stays have certainly moderated in terms of their changes.

Also, I think there are a number of us concerned about the mix of a per diem philosophy with the DRG averaging philosophy. This is even complicated further by the fact that we now would have the DRG averaging philosophy, the transfer policy, and the modified transfer policy. It does become a bit complex in terms of the way that it affects incentives.

Also, there's a number of comments in the text about overpayment and paying twice. One of the concerns I have does have to do with some of the complex cases that are currently being transferred into hospital-based SNFs. I think it's the belief of some of us that even with what might be considered double payment, the combination of the two payments is probably not covering the total cost of care, particularly when you look on the SNF side at some of the negative margins and the fact that there are more patients going into those hospital-based SNFs that are of

the high acuity and complex non-rehab patients.

I'm also a little bit concerned about the statement that this will have a negligible effect on beneficiaries. I don't know what the effects might be, and certainly no one does, of extending this to all DRGs. But if we should see an acceleration of exiting of hospital-based SNFs, I think access to care on the part of those higher acuity, more complex patients could possibly be affected and I think we should be mindful of potential unintended consequences.

Then lastly, you showed a chart on the relationship of short stay transfers and margins which I noted is in our text and our handout as well. What strikes me there is that 58 percent of -- excuse me, it's about 74 percent of hospitals are discharging between 25 and 33 percent of their cases to post-acute care. That's a large number. That's the second and third lines on this chart. That's a large number of hospitals.

But this particular group actually has a ratio of actual to expected length of stays that are within the normal range. They also have Medicare inpatient margins, after your adjustments, that are not very healthy. I think that we're targeting in this policy, it appears we're targeting the bottom two lines which represent somewhere between 3 percent and 15 percent of hospitals. I'm very concerned about the effects of expanding the transfer rule to all DRGs because it's going to hammer 75 percent of hospitals who are ill-prepared to accept it, even though if there is a rationale to it, it may be targeted to that 13 percent and 3 percent of hospitals that are on the lower two lines there. And if you look at the margins of rural and other urban hospitals, I think my concerns would be echoed there as well.

So I think there are some significant issues here that perhaps haven't been entirely worked out.

DR. NEWHOUSE: I'd like to make a couple points. One is in response to Nick's point that this somewhat mixes the averaging principle and the per diem principle, which I agree, and also somewhat in response to the points and the mail that we've all received that this undermines the averaging principle.

The point I want to make is, the averaging principle isn't necessarily a good thing. If you have cases that you make profits on and cases that you take losses on,

you have incentives to want to try to attract to your institution the cases you make profits on and shunt off to somebody else's institution the cases that you take losses on. So trying to cut down the variation within a DRG in what we pay for relative to cost -- that is, to cut down the absolute amounts of profits and losses seems to me a good thing. So to the degree that we're undermining the averaging principle by doing that, that seems to me a good policy.

The second point I wanted to make, and this is why I favor option A because I think this is basically good policy, but we have had, in terms of the difference between A and B, either way we add the 13 and the only issue is whether we stop or not. We've had this policy is for several years now; if I remember right, since '98. I think the BBA put it in, although I can't remember exactly when it was implemented.

MR. LISK: Fiscal year '99.

DR. NEWHOUSE: As far as I know, nothing terribly bad has happened in the 10 DRGs where this policy has applied. So I don't think there's a very good case for thinking that we would learn a lot that we don't already know from evaluating what happens to 10 more DRGs.

Now the issue of, what about the overall budget impact I suggest we defer until next year, because for this year we're only going to consider these two options, adding the 13 DRGs. We can face next year what would happen in the update factor if we go beyond the 13 DRGs.

DR. WOLTER: Can I just respond to Joe's first point because I absolutely agree with it. I think we shouldn't probably have a system where incentives are to carve out certain DRGs, which by the way is going on all across the country right now. I'm just not sure this actually will have the effect of equalizing out where the bottom line is in certain DRGs versus others.

DR. NEWHOUSE: That wasn't my -- it's not the between-DRG variation, it's the within-DRG variation. So what the transfer does is it cuts down the profits I make on my short stays, and therefore my incentives to try cream off the short stays. Then depending on what happens in the base rate -- meaning the mean payment -- it doesn't do anything about the far right but it potentially shifts also right around the mean.

DR. WOLTER: I think that's the problem I'm

raising, is that we're focusing on the short stays but we may not have full information about how we're doing on the longer stays, and will we end up in a good place? When you look at 75 percent of hospitals, the we extend to all DRGs, having 1.3 percent of their payments taken out when they're already at inpatient margins with these adjustments of -0.9 to 1.8, I think that's a significant problem. At the very least it would argue for retaining the money in the system at least until we can see how the three-year reweighting of DRGs turns out.

DR. MILLER: But the point of that table -- I don't think you're incorrect, but the point is that those hospitals use post-acute care transfer significantly less than other hospitals. That is one point here.

DR. WOLTER: They use it 25 to 33 percent of their discharges, and yes, that is significantly less than those using it 43 to 50, but it's still a significant number of their cases that they're discharging to post-acute care.

MR. LISK: No, it's the first column. It's the first column in terms of the percent of cases that are affected by the policy.

DR. WOLTER: What's the third column then, Mark, where it says percent of cases discharged to post-acute care?

DR. NEWHOUSE: It's all cases discharged to post-acute and the first column --

DR. ROWE: It's just the short stay that they're focusing on, Nick, so it's the left-hand column. It's a very small effect for those first couple hospitals.

MR. LISK: We're just showing that of those who have a lot of short stay transfers, they do have more cases that are discharged to post-acute care.

MR. HACKBARTH: Can we turn to the recommendation page for a second? Joe, you had a comment on the structure of the recommendations that wasn't sure that I followed.

So some other reactions on the two recommendations that are on the table? We can just wait and then vote sequentially on them, or if there's a clear consensus we can save ourselves some time later on. Any thoughts?

MR. MULLER: A brief question. Insofar as we think that these transfers are largely driven by financial rather than clinical considerations, if we change the financial incentives wouldn't we therefore logically assume that they'll change their behavior and then we don't save

any money on this?

MR. LISK: No. We're not implying that the first point that you're making is that this is perfect -- in terms of what hospitals are doing in terms of discharging these cases of short stays is likely perfectly clinically appropriate. What we are saying though is that because those cases needed to be discharged to post-acute care, that less services are being provided. If those cases weren't discharged to post-acute care they would have stayed in the hospital longer and had higher costs.

So what we're accounting for is site of care substitution that may have occurred for those short stay cases and reducing the DRG payment for those instances where that occurs.

MR. HACKBARTH: Any other pressing comments on this one?

MS. DePARLE: Just a question. In the letter that we got from the American Hospital Association, I think maybe in the comments that they made at the last session of public comment period, they suggest a concern that the recommendations we were considering at the last meeting did not suggest returning the savings from this policy or from expansion of the transfer policy to the base DRG rates, which they say was a concept that MedPAC endorsed in June 2001. I wasn't here then. I just wondered if someone could comment on whether that's the case and what the thinking was then.

MR. PETTENGILL: That was discussed in the June 2001 report which was about health care in rural America and Medicare in rural America. The context was ways in which -- and actually it was a mistake, I think to put together the redistributive impact of the expanded transfer policy with the question of whether aggregate payments are adequate in the prospective payment system. They're two separate questions.

If you believe that the transfers result in less service to patients and therefore less cost to hospitals, and you shouldn't pay for something you're not getting, then you should take the money away. And if it turns out that you also believe that payments are not adequate in the aggregate, then you should do something about that. But it's a separate issue.

DR. WOLTER: I'll try one more time. If you look at the distributional impact of expanding transfer policy to

all DRGs, I think at least the point I was just trying to make at least partly holds, because even if you're transferring patients who are affected by the policy somewhere between 2 percent and 10 percent of the time, if the transfer policy extended to all DRGs it would reduce payment by 0.7 to 1.3 percent, if I'm reading this correctly. And that would be the group that always has inpatient margins with your adjustments of -0.9 to 1.8 and I think that's a concern.

MR. PETTENGILL: Nick, it's actually the group that has margins in that range after you exclude revenues from DSH and IME above cost.

DR. WOLTER: I understand that.

MR. PETTENGILL: Which isn't the same thing. If you wanted to know the answer to that you'd have to look at the inpatient margin, the full inpatient margin, to tell you where hospitals really are. We took the DSH and IME above cost revenues out because we didn't want them to distort the pattern that you can see in the margins on the base rate.

DR. WOLTER: I understand that, although if you look at other urban and rural margins, as you've just suggested, I think that the transfer policy, since it's roughly going to affect them the same as other groups, the impact I'm talking about would exist.

MR. HACKBARTH: I sense a waning of our collective energy, or at least my individual energy, so I'm going to ask that we move ahead. Again, we will come back to vote on the recommendations at the end.

Next up is the previous MedPAC rural recommendations. Here I think we can move very quickly, if not at the speed of light, since these are -- we have considered these at length. They are recommendations that we have already made in other contexts. So if you could give us the one-minute version, Jack, that would be real helpful.

MR. ASHBY: All right, I will be unusually brief then, especially for me, I suppose.

This first slide I'll just pass right over. This speaks for itself. We have four previously made recommendations. To get right on to the first of them, implementing a low-volume adjustment. Just in short, the rationale was based on the fact that hospitals with low volume really do have higher costs, and they have lower margins. So with that I'm going to go right to the draft

recommendation.

The recommendation language is pretty clear; enact a low-volume adjustment. But we do have an issue here that we need to talk about that came up last time. That is that ideally we want to restrict the adjustment to hospitals that are playing a significant role in protecting access to care.

There are two ways that we can do that. One is the one that we raised last time, that we could restrict it to hospitals that are more than 15 miles away from another facility. But it was suggested that since the savings from doing so are very small -- and indeed, that is the case, they are very small -- perhaps we ought to just not bother with it and make the adjustment available to all low-volume hospitals.

But I did want to point out one potential problem with doing so, and that is that we have anecdotal evidence that suggests that some very small specialty hospitals have been built or in the process of being built in urban areas that might then qualify for the adjustment. Clearly, it seems that facilities of that type would not be in need of special assistance and to give them that, or to let them qualify might further unlevel the playing field for specialty services.

So one simple way to get around that problem is to simply say that we restrict this adjustment to hospitals that are located in rural areas. But that's not airtight. It's conceivable we could have a specialty hospital in a rural area. Also conceivable you could have an isolated hospital that's in a nominally urban area. So we have to pick between these two.

MR. HACKBARTH: If I may I'd like to cut to the chase on this one. I recognize the dollar impact of the 15-mile limit is minuscule. To me it's more important as a conceptual point than a fiscal point. I don't think that we ought to be in the business of providing additional payments to low-volume hospitals that are low volume just because they're next door to another hospital. Just as a matter of principle that would bother me, even if the dollar effect were small. So I would strongly recommend that we stick with our original formulation which was option number one here.

MR. FEEZOR: I just think 15 is too small.

MR. HACKBARTH: That may be, but we could spend the next 45 minutes debating what the right number is and

I'd just as soon not do that. I think the point is made with recommendation number one.

Okay, Jack, next up?

MR. ASHBY: Next up is re-evaluating the labor share. In short, we have evidence that suggests that the labor share may be set too high but we have not yet done an analysis that is designed to isolate the "best" labor share for the hospital industry as a whole. So because of that we have worded the recommendation in this general way, that the Secretary should re-evaluate the labor share that is used --

DR. NEWHOUSE: Jack, why do we have to have one labor share for the industry as a whole if the labor shares importantly differ between urban and rural areas?

MR. ASHBY: I think the concern is that if we get into multiple labor shares then we set up a scenario where there may be an incentive to manipulate your labor share. And that's the last thing we need is to have one more opportunity for hospitals to do things to maximize their payments.

DR. NEWHOUSE: Wait a minute. You've still got hundreds of hospitals in each of those categories so if you manipulate your share you're still not doing anything to the mean.

MR. ASHBY: That of course depends on how far you go in disaggregating it. But let me point out too that the research suggests that if we had a separate labor share for urban and for rural what we would actually end up with is the labor share would be higher in rural areas and not lower.

DR. NEWHOUSE: How much higher?

MR. ASHBY: That again gets back to the analytical thing. It's really hard to peg that down.

DR. NEWHOUSE: I was going to your issue that you were going to spend time analyzing the best single rate, and I'm not sure that's the best way for you to use your time, but I'll see what others have to say.

MR. HACKBARTH: Joe, I can see your conceptual point but it doesn't seem timely right now. We could have raised that issue sometime in 2001 when we first considered this recommendation. So if we want to at a later point open up that conceptual issue we can, but it's too late for this purpose.

DR. NEWHOUSE: It goes to how this draft recommendation is going to be implemented, what we mean by

it.

MR. HACKBARTH: This assumes a single labor share and that's what it's been since we first considered it two years ago. If at some point in the future, in the next cycle we want to say, maybe we ought to think about, okay. But we can't resolve that today. We're voting now, not opening up new issues.

MR. ASHBY: The budget implications of this one are none. This would be implemented budget neutrally.

The third recommendation has to do with eliminating the base rate differential. Here again the evidence is pretty clear that there is no rationale for a differential and the margins are in the same direction.

So the draft recommendation here reads, implementing this, phasing out the differential over two years. Here we do need to make note of the fact that there are budget implications here. The increase would be in the category of $200 million to $600 million in one year, and in the category of $1 billion to $5 billion over five years.

I did want to point out too that one of the concerns we received from industry here was that this should be structured with new monies and not with a differential update, and as we can see that's what we are proposing to do in this case.

Then the last one has to do with raising the cap on DSH payments. We don't need to go through this again too but I did want to just remind everybody there is a larger major reform in the offing here and that this is an interim measure to get us through to the point where uncompensated care data will be available and we can then reform the entire system.

The recommendations is drafted as simply raise the cap from 5.25 to 10 percent. But we have an issue here left over from the last meeting and that is whether to phase this in over two years or five years, as we see on this next page. Both the Senate and the House proposed the five-year phase-in in their respective bills last summer. The two-year phase-in, on the other hand, would first speed relief, if you will, but also it in theory would allow us to be done with this phase-in by the time the uncompensated care are available to reform the system. Although I have to put in a major cautionary note that that's in theory. The odds of a complete DSH package being ready to implement two years from now are probably not very good, but in theory it could

happen.

MS. BURKE: Jack, could you just remind me in short form of what the intended newly, great revised DSH payment strategy is supposed to be?

MR. ASHBY: The larger reform?

MS. BURKE: Right.

MR. ASHBY: The larger reform would do two things. One is it would bring uncompensated care into the calculation of low income shares that are used to distribute the payments. So we would be allocating the payments more closely to the actual uncompensated care that hospitals have.

But the other objective of it was then to treat all hospitals equally. The thought was once we are using the correct allocation mechanism then why not have a single distribution formula for all hospitals?

This one again does have --

DR. WAKEFIELD: Can I ask a question?

MR. ASHBY: I was just going to do the budget implications but you can go ahead an ask a question if you like.

DR. WAKEFIELD: Go ahead with the budget --

MR. ASHBY: I did have to point out that this does have budget implications. It would increase payments in the category of less than $50 million if we go for the first year if we go with the five-year phase-in, and it bumps up to the $50 million to $200 million category if we go with the two-year phase-in. Under both phase-in approaches we end up in the less than $1 billion category over five years.

DR. WAKEFIELD: I just wanted to express support for phasing this in over two years. There's ample justification for raising the DSH cap. A year has already ticked by, at least, in the time since we first made our recommendation. While I understand that the issue here might be budget implications, I also think that there's some real inequity for rural hospitals until this cap gets raised. So I understand why we've got it phased in over five years, but I think that that's holding rural hospitals hostage in a way that our evidence would suggest is inappropriate. So I just wanted to speak to that.

MR. HACKBARTH: I agree with that. I too would like to see it two years. It seems a bit anomalous to me to say, this is a stopgap change in lieu of the overall reform but we're going to implement it over a five-year period. I

think the issue is a bit more urgent than that, both financially and in terms of equity, so I would like to see us do it in two years.

MR. ASHBY: All right, then on our speed-through technique we just have one more slide and that is the impact of these four rural recommendations. Let me go right to the -- first of all, let me point out that on the left we have the baseline margin here. This is kind of a new concept. This is the actual 2000 margin then adjusted for the 2001 increase in DSH payment and the 2003 cut in IME payment. It's a better indicator of our starting point going into these recommendations.

If you would go to the rural line you'll see that the impact is a one-year impact of an increase of 1.3 percent in their payments. That is with the two-year phase-in that we were just talking about. Notice also that despite this package being billed as improvements in rural hospital payments, there is also a 0.8 percent increase in payments for other urban hospitals. That's due to elimination of the base rate differential.

Finally, you'll notice that larger urban hospitals do lose 1/10th. That is due to the labor share issue. That one is redistributive, done budget neutral. So these are the impacts, unless anybody has any questions.

MR. HACKBARTH: Thank you, Jack. I think we're ready to move on to the inpatient update. Are you doing that as well?

MR. ASHBY: No, Tim is.

MR. GREENE: As we discussed earlier you're considering the update for inpatient payment rates for fiscal year 2004. By current law the payment rates will be updated by the rate of increase in the marketbasket, unless Congress acts otherwise. $86 billion was spent on inpatient PPS payments in 2001. This is forecast to increase at a rate of 6.4 percent a year, reaching $103 billion in fiscal year 2004 according to CBO. Inpatient PPS payments affect care for almost 12 million Medicare discharges.

Now as we've discussed previously, the MedPAC update approach and the payment adequacy framework first looks at payment adequacy in the current year, which we've addressed, then turns to changes in costs of efficient providers anticipated in the payment year. In this context we consider changes in input prices and other factors. CMS measures input prices, as you know, with the hospital

marketbasket, the operating marketbasket in this case.

MR. HACKBARTH: Tim, I don't want you to feel left out. I'm going to harass you equally with everybody else. I'd really ask that we move to the bottom line here. We're familiar with the framework and all that. In this case I think people even know the bottom line pretty well.

MR. GREENE: Agreed. As you can see, marketbasket is growing but it's forecasted to grow more slowly, mostly notably 3, 4, and 5 percent in the payment year, considerably less than now, which parallels what I was describing earlier which is slowing growth in hospital wages. As you know, we take countertechnological change, or make an allowance for technological change. We estimate 0.5 percent in addition to hospital costs would be appropriate to take account of anticipated technology costs. We base that partly on the fact that CMS has approved only one new technology this year for payment under the inpatient technology pass-through program, which suggests that there's not that much with great expenses out there.

Finally, we make a productivity adjustment. We use a ten-year average of multifactor productivity measure that's been discussed several times. It's a measure the Commission has used for some time and it shows steady grown over the last decade. So the numbers we're seeing here are considerably higher than they would be two, three, four years ago.

The draft recommendation states that the increase in PPS inpatient payment rate should be set increase in the hospital marketbasket less 0.4 percent. That reflects an allowance for science and technology of a half a percentage point, net of a 0.9 percent adjustment for anticipated productivity change.

Budget implications are a reduction in spending since current law would be increase in the marketbasket and the recommendation is increase in the marketbasket less than 0.4 percent. We expect a one-year savings between $200 million and $600 million in that budget category and a five-year savings of between $1 billion and $5 billion.

I'll take any questions or we can just -- do you want me to go on -- do you want to discuss it or continue --

DR. MILLER: Let's do the impacts.

MR. GREENE: This is a summary impact table that pulls together the marketbasket information and the update offset, the -0.4 percent and the distributional impact

information that you saw earlier. The distributional changes reflect the rural recommendations and the IME recommendation you've been discussing, and transfer.

MR. HACKBARTH: This is the whole --

MR. GREENE: This is the whole package, right.

MR. HACKBARTH: This is the net effect of everything in the inpatient package?

MR. GREENE: Yes. The DSH case we include is the two-year phase-in.

DR. MILLER: Though it has minor effects if you go the other way.

MR. GREENE: Yes, it makes some difference.

DR. MILLER: Overall. The way to absorb this table, moving from left to right is, the marketbasket increase in current law is currently estimated, the straight reduction off of the update, that recommendation, the -0.4, and then a set of distributional changes from IME, and transfers, and the rural policies, and then a net -- the actual increase in payments for the sets of hospitals after those changes. That's how you read that table from left to right.

MR. HACKBARTH: So looking at that first of row of all, with the combination of the update offset and the distributional changes, we're talking about for the aggregate package a net effect of marketbasket -0.7. Am I reading it correctly, Mark?

DR. MILLER: That's right.

MR. ASHBY: I think the thing to remember is this is all 2004, so this is the first year in all cases. There's about five different recommendations that have a first-year impact and that's what we're capturing.

MR. HACKBARTH: Any questions about this? About this table in particular?

MS. RAPHAEL: No, about an earlier table.

DR. REISCHAUER: Just one reminder about this table which is that while columns one and two apply to every hospital, column four is the average for groups. So within the group there will be different hospitals coming out differently.

MS. RAPHAEL: I just had one quick question, Jack. On the chart that says accounting for cost change in the coming year, you have hospital marketbasket increases and forecast. The ones for '01 and '02 were the actual increases?

MR. ASHBY: Yes.

MS. RAPHAEL: Are there errors in what we forecast, and how are errors handled in the hospital update?

MR. GREENE: They're not reflected in the update. These numbers are actual historical numbers now, the 2001, 2002. '03 and '04 are forecasts. We don't make explicit adjustments for forecasts error.

DR. MILLER: But, Tim, when we forecast forward for purposes of calculating the margin, we use --

MR. GREENE: The actual historical --

DR. MILLER: If that data has been corrected, then we use the corrected data; is that right?

MR. GREENE: Yes.

DR. MILLER: So in that sense, for judging where they are -- and I don't want to say this wrong. We do use the accurate marketbasket.

MR. GREENE: Yes, certainly.

MR. HACKBARTH: We don't recommend each year that the policy -- the recommendation for the update go back and correct. We reflect it for underlying analysis of what's happening. We used to do that, but that's one of the things that we changed when we went to the new framework.

Anything else that you needed to present?

MR. GREENE: We just didn't go back to the margin chart. You saw this before. I'm putting it up again because it is of interest in the decision-making process. As you recall, our estimate of the overall Medicare margin for 2003 is 3.9 percentage points compared to 5 percent in 2000, with an increase in rural and decreases in other categories.

MR. HACKBARTH: Just to be clear, this is the original estimate of margins. This is not adjusted to reflect the policy recommendations.

MR. GREENE: Exactly.

MR. HACKBARTH: Okay. Are we ready to move on then to the outpatient update?

MR. ASHBY: Did you want to do the outpatient update first before we vote on the inpatient? I thought we would complete the inpatient first.

MR. HACKBARTH: Why don't we get it all out, Jack, and then come back to the recommendations? Thank you.

Chantal?

DR. WORZALA: Good afternoon. I'll try to be as brief as I can. I know it's getting very late.

This presentation looks remarkably like the one you saw in December so I'll only highlight what has changed. This is some information for you that gives background and context. We are doing an update for calendar year 2004. The current law update is marketbasket.

Tim previously went through payment adequacy for the hospital as a whole. These are the things that he looked at.

Here I'm present you some new information which gives you our outpatient margins for 1999 and 2000. I'm giving you the sector specific numbers primarily as a point of information for purposes of comparing across groups and to show the change from '99 to 2000. You'll recall that the outpatient PPS was implemented in August 2000 so these 2000 margins here do span the implementation of a new payment system. Since hospitals have different cost reporting periods, the margin calculation has a mix of pre-PPS experience and post-PPS experience.

Given this, we did calculate the margin for all outpatient services, not just outpatient PPS services. This also allows us to compare over time since we previously didn't have an outpatient PPS

The outpatient margins are negative. The average across all hospitals was -16.4 in 1999, increasing to -13.7 in 2000. We don't know the true outpatient margin. This is our estimate of what the cost reports tell us. We think that much of the large negative numbers here are attributable to the cost allocation issues that Tim described previously, where the inpatient margins tend to be overstated and the outpatient margins understated. The best estimate we have of the overstatement of outpatient costs is 15 to 20 percent.

The increase in the outpatient margin from '99 to 2000 is consistent with policies implemented under the outpatient PPS. PPS included hold harmless and transitional corridor payments that put new funds into the payment system. In addition, the pass-through payments were not implemented in a budget neutral manner until April 2002, so extra funds were put into the system through the pass-through payment.

In looking at urban versus rural hospitals, the margins are fairly similar although the improvement from '99 to 2000 is greater in urban hospitals. Of course the last two columns on this table show the overall Medicare margin

which we feel is the most appropriate for assessing payment adequacy, and it puts the outpatient margins in the context of a hospital as a whole.

The update factors that we considered are those that you've heard a few times today. The outpatient PPS is a bit unique in that technology costs are addressed specifically through two mechanisms, the new technology APCs which are not budget neutral payments so each service provided does result in additional payment. There about 75 services covered by new tech APCs in 2003. There are an additional five applications under review. An example of something covered under a new technology APC is a PET scan. Since these costs are dealt with directly and result in additional payment we don't see the need to factor that into the update calculation.

The pass-through payments, as we've discussed before --

MR. MULLER: We usually have 0.5 on technology. Is that worth 0.5?

DR. WORZALA: Are you saying, have the new technology APC payments equal to 0.5 percent of the total?

MR. MULLER: Yes.

DR. WORZALA: I think we would have to look for another year of experience. I haven't actually calculated but it would be slightly less than that, I think, in the 2001 experience. I wouldn't want to give you a number until I'd done the math but I would guess that it's closer to 0.025 rather than -- that's my quick math in my head.

MR. HACKBARTH: There are other instances where, because of the structure of the payment system, we take a productivity adjustment but do not add back anything for technology. For example, physician payment. There the logic is, we're talking about such small bundles that the way new technology is reflected there in higher expenditure is by new procedures being added and being used more frequently. So it's more or less self-correcting.

Here we're applying that argument plus the additional argument that we have the new service APCs as an automatic mechanism. So that's the reason for not using the policy factor of 0.5.

DR. WORZALA: That's right. Then for other kinds of technologies that are not new services we have the pass-through payments for things that are an input to a service such as a drug or a medical device, and those are covered

through the pass-through payments.

That is a budget neutral provision. However, it looks like in 2003 payments will equal the pool set aside for pass-through, so this isn't a place where we're seeing large pro rata reductions in the pass-through payments which might then need to be factored into the update calculation.

Looking forward, there are about two dozen drugs and five devices on the pass-through list in 2003. There are less than 10 applications for additional new technologies pending which suggests there's not a whole lot of action in this area.

Also, just on the pass-throughs, note that we did end up putting extra money into the system through the pass-through. In 2001, pass-through payments should have been limited to about 2.5 percent of total payments but they came out to be about 8 percent of total, payments. So there was excess spending of about $750 million on these items in 2001. For these reasons we've determined that technology costs do not need to be factored into the update for 2004. The final factor would be the productivity increase.

So putting these things together, we go to the following draft recommendation for your consideration. The Congress should increase payment rates for the outpatient PPS by the rate of increase in the hospital marketbasket less 0.9 percent for calendar year 2004. This recommendation would decrease spending in comparison to current law. The one-year impact falls into the category of savings between $50 million and $200 million, and over five years the savings would be in the category of between $250 million and $1 billion.

That's it.

MR. HACKBARTH: Questions or comments?

Okay, I think we're ready now to turn to voting on the recommendations.

MS. ROSENBLATT: I just want to make a general comment on the recommendation that Glenn and I discussed but I wanted to get this out publicly. I've been quiet all day.

There was a comment that I think Tim made about less pressure from other payers, which I don't believe is true at all. Alan is laughing with me. There's been a lot of pressure from other payers, but I think that the situation is changing as evidenced by the decrease in the margin that we're seeing. I have an overall concern about the impact of the total package here. The modification I

would suggest before we vote is that even though Julian said it was not the right thing to do, theoretically when Nancy-Ann raised the point of putting the distributional effects back into the base my concern, given the trend line on these margins, is that we should put -- that our recommendation should be to put the distributional impact back into the base.

If I understand the numbers correctly, each 1 percent is worth about $1 billion, so 0.3 is about $300 million is my guess.

MR. HACKBARTH: Actually it wasn't Julian who said that that wasn't the right thing to do.

Let me just go through these one by one. I think the argument for doing it on a budget neutral basis has been most prominent around the transfer policy. A number of commissioners mentioned it in that context. There are clear arguments for doing it that way.

But I think if we start doing these distributional changes on a budget neutral basis we cannot single out that one and we've got to do it elsewhere. So next on the list I think would be going to a single standardized amount, and you would need to do that on a budget neutral basis. The current recommendation is to do it with new money.

Now the net budgetary impact of going to a single standardized amount is to increase outlays by 0.3 percent. By coincidence, the net effect of the transfer policy, not on a budget neutral basis, is a -0.3 percent. So they're basically offsetting. So I think the net effect in terms of how much money goes into the pool of those two is the same whether you do them budget neutral or not, just because by coincidence they happen to be offsetting.

There are all other proposals in here like the IME proposal where, at least I personally, and other commissioners may disagree, feel like the Congress has clearly established that those changes are not budget neutral. The Congress, when it has changed the IME adjustment has taken savings for that, or when they've frozen already enacted reductions, that they've added costs for that. So for us to pretend like we can set one set of rules about budget neutrality independent of what the Congress has done I think is -- that's just an academic discussion.

Some of the other pieces like reducing labor share we've always talked about as being budget neutral

conceptually. So if you go through them one by one I think you end up in the same place in terms of the bottom line impact. The two big ones again are transfers and the standardized amount and they happen, just by coincidence, to be offsetting. So I think we could spend a lot of time talking about this only to end up at the same place in terms of the dollars going into the system. That's why I've tried to -- we have enough complicated issues ongoing and I just didn't think that that was a productive use of our collective time.

MS. ROSENBLATT: Let me also raise the issue -- Carol was very eloquent before about let me just give you a warning. I want to say the same thing. I am concerned about the impact of this package on commercial premiums due to the cost shift effect, which we've got historical evidence that whenever the hospitals feel pressure, it shifts out. We're already seeing double-digit increases. Would it be possible to modify the recommendation, because we're dealing with year 2000 data and updating it -- that if we see some kind of trigger -- and I don't know what that trigger is going to be -- that there may be time to change it. But I do have concerns and I think a warning is necessary on this package.

MR. HACKBARTH: The normal global mechanism for dealing with changed circumstances, projections that turn out to be in error is, for better or for worse we do this every year. And Congress, if something happens in the next several months they can always take it into account, and in any event we'll all be back to it again next year.

Again, I'd like to try to establish some context for this. The aggregate impact of the whole hospital inpatient package is marketbasket by minus 0.7 percent, which certainly isn't out of the norm of what's happened recently through the legislative process if you look over the last 10 years or something. If you look at MedPAC's recommendation of last year, the aggregate impact was marketbasket.

The real difference when you boil it all down between where MedPAC was last year and this year is the transfer policy and the IME. Those are important policy changes and everybody's going to have their chance to vote on them in just a minute. But I don't think that either one represents a policy that came out of left field. They are ideas that this commission and others have debated for a

long time. So in that sense, I don't think that we've been hasty by any stretch on either of those issues. I think we've been quite deliberative.

So what I would ask is that we turn to the process of voting on the recommendations.

DR. WAKEFIELD: Glenn, are we going to hear Jack's recommendation before we vote on the IME, the first one? In other words are these at all mutually exclusive?

MR. HACKBARTH: I think that's a good point, Mary. What I would like to do is vote on the recommendation. This thing has been around. I think we need to vote up or down on the original staff recommendation, and then we will vote on Jack's. But I think all the commissioners ought to hear Jack's before the first vote so, Jack, do you want to go ahead?

DR. ROWE: Yes. Let me explain what I have in mind that's up there. Congress should phase out the portion of IME payments beyond the empirical costs of teaching over the course of four years, and during that time establish and implement a mechanism to broaden the definition of empirical costs of teaching to include explicit expenditures that enhance educational effective and innovation and increase the quality of care.

Now what I had here, before we go on, is I don't what to go sideways for four years while we study it and then decide that we're going to start cutting it, and then we'll be here like we have been in the transfer and other things saying, four years wasn't enough and we need to study it longer, and just a couple more years, et cetera. So I want to have a trigger that this actually starts to decline as this thing has to get phased in, so somebody is going to have to start for doing something fairly soon.

Then it goes on, such funds should be allocated on the basis of measurable outcomes. Leave that ambiguous as to -- that's not quality of care necessarily. That may be process outcomes. They have to prove they did something. These expenditures might include information systems, development and implementation of new clinical curricula, and interdisciplinary clinical training programs.

The next recommendation that I write will be my second, so I don't have a great pride of authorship, so cut me some slack here, but this is, in general, what I think we discussed.

DR. NELSON: Jack, I can see how this could

involve a separate category of cost reporting that could be an enormous hassle, in addition to the current hassle. That's enough for me to worry about this and vote no just on that basis.

DR. ROWE: Then it goes away. That's the option, I think. I'm open to suggestions about how it could be done otherwise, but I don't think there's much appetite in Congress for just giving -- the idea here is to get rid of the subsidy and give money for something explicit. If that's the idea, then they have to report that they actually did the thing that we're paying for, and you can't do that without reporting. I think it's not realistic to think that Congress is going to just keep giving the subsidy and they can spend it for whatever. There's got to be some discipline, I think.

MR. SMITH: Jack makes the best case for supporting his substitute when he argues that the alternate is that the money goes away entirely. I don't know whether he's right about that or not. But I do know that if we support Jack's motion which encourages activity that we ought to want to encourage, and we do it in a way that requires that the funds actually be spent on that activity, that hospitals will no longer be able to spend money on whatever they're now buying with the portion of IME above the empirical costs. We have evidence -- we don't know entirely what they're buying, but we have evidence that the hospitals that get the most of those resources are also the hospitals that do the most buying of something we all care about, which is the purchase of -- payment for uncompensated care.

The only reason about for -- if you are concerned about the staff recommendation for those reasons, the only reason to vote for the Rowe motion is because you believe that the alternative is that we get nothing. I think that's unwise as a matter of policy and certainly cloudy as a matter of prediction and I hope we'll forbear at this point and vote no on both opportunities. That we will vote no on the recommendation as presented originally had should -- we would then be asked to vote one way or another on Jack's substitute and I'd hope we'd also vote no, meaning we'd have no recommendation.

MR. MULLER: Glenn, if I understand your process, if we vote no on the staff recommendation then we can either decide to go to Jack's motion or not go to it.

MR. SMITH: Presumably we'd go to it.

MR. MULLER: So if we vote no on the staff recommendation, we can then decide whether we want another motion or not, if we vote no. So why don't we vote on that and then we see whether --

MR. HACKBARTH: I'm not 100 percent sure that I'm following implication.

DR. REISCHAUER: They're saying we don't have to have a debate about the merits of Jack's because if there's huge support for the staff recommendation, which I sense in the room, then Jack can just go home.

MR. HACKBARTH: If, I suppose, is the key word there. I'd like to just vote on both of them sequentially. Jack's would be in the nature of a substitute. So let's say, just for the sake of argument that there was a majority for yes on the first one, then you wouldn't be voting for Jack's. You'd vote no on Jack's.

MR. SMITH: Or yes. It seems to me, Glenn, that some of our colleagues are likely to be willing to vote no on the staff recommendation because they have an opportunity to vote yes on Jack's. So it seems to me you need to offer us the following option. Regardless of how we vote on the staff recommendation, we then either get to vote on Jack's as a substitute or on Jack's as a freestanding resolution.

MR. HACKBARTH: That's what I contemplate is there will be two votes, right.

MS. BURKE: Just the following, prior to the vote. I would hope, not knowing what the outcome of the vote would be, but were the outcome of the vote that neither policy was agreed to, I would hope that that wouldn't prevent a conversation from occurring at some point that very much follows Jack's track, which is that we need to move to a policy that essentially explicitly pays for a particular activity if we in fact fundamentally believe in the activity.

And I would hope that if, for whatever reason, it remains an option for the future, even if we pass the staff recommendation, I think it is something well with discussing in some detail. I think there are some issues about how one does it that are a problem here, but I think philosophically it's something that ought to be discussed.

MR. HACKBARTH: So what I hear you saying is, some people might feel compelled to vote no because it's not quite formulated the right way, but that shouldn't foreclose

all future discussion of the concept.

DR. STOWERS: I wonder on Jack's if anyone would object to just limiting it to the first paragraph. It seems like to me that that gets too specific. I think what we're looking for is to redefine the empirical thing, and then we have those goals there, and the what Alan is saying. I think we'd be just better to stay with the very first --

DR. ROWE: It's a reflection of my naivete as a recommendation drafter.

DR. STOWERS: The other could go in the text .

MR. HACKBARTH: I agree with that, Ray. I think sometimes adding more isn't helpful and actually makes it worse.

DR. ROWE: If I had more time to draft it, it would have been shorter.

MR. HACKBARTH: Right. Thank you, Mr. Twain.

So on the particular issue, is there agreement that Jack's -- I guess it's up to Jack, isn't it, if he wants to just offer the first page, it's his choice.

DR. ROWE: Sure.

MR. HACKBARTH: So we're going to just do the first page on Jack's. All right.

DR. WAKEFIELD: Could we hear the first part of Jack's again please? Jack are you suggesting that those dollars for educational effective and innovation, and increasing quality of care, would be retained by teaching hospitals? That, is, the facilities that currently are receiving those IME payments? Or does this have any implication for, for example, residency training in primary care settings or other kinds of settings that speaks to innovation and increasing quality of care, et cetera? Where are those dollars going to go? Are they going to continue to drive into the facilities that are receiving these IME payments today or are we talking about the potential to enhance educational effectiveness even outside of the facility?

I also want to make the comment on interdisciplinary team training. I'm a big advocate of that, having served on the Quality Chasm committee report, been part of all of that. I also say that, frankly, if we're starting some of that at residency training or graduate nursing training or anyplace else, we're starting out way too late. That's the kind of thing that needs to be embedded in the first year of medical school as far as I'm

concerned, and the first year of nursing and so on. So those are important things to target that were on the second paragraph but I'm not sure that residency training is the vehicle for getting there.

The last thing I'd say is if we're concerned about quality of care and access to care, we've heard repeatedly -- and we're now talking about this for educational purposes -- we've heard repeatedly about the lack of access to nurses and implications for access to health care services for Medicare beneficiaries. While we don't want to go there either, I'd say if now we're going to refocus our attention on education for quality and education for access, we've seen data that show us clearly the linkage between numbers of nurses and facilities and poor patient outcomes, and we also have heard repeatedly from the different sectors of the industry about linkage between access to that part of the nursing workforce.

So that's just my 30 seconds on it, sort of a sidebar issue.

DR. ROWE: Let me respond, Mary. My intention was that the funds would go to support education. My focus is that we have been giving money to them under the rubric of education but they can use it for anything. I'm concerned that clinical education is becoming archaic and we need to stimulate a rebirth of it. I'm interested in having the funds going to any institution which is doing clinical education. Anybody who's got a residency program or whatever, I don't care whether it's defined as a teaching hospital or not. But if it's a hospital that doesn't have any educational activities, I wouldn't put it there.

I don't mean to exclude having interdisciplinary training in the first year of med school, but we're talking about the Medicare program and clinical expenditures. So I threw the interdisciplinary training in there in order to try to get your vote.

[Laughter.]

MS. ROSENBLATT: Jack, given the brave new world that you described earlier, let's suppose there was an e-learning company. Would the money go only to providers or could it go to an e-learning company that was going to do terrific things, or a disease management company that was going to educate beneficiaries? I guess where I'm coming from is --

DR. ROWE: We're talking about payments to

hospitals.

MS. ROSENBLATT: I'm not sure that I want to throw additional money to hospitals because maybe in the brave new world there are ways to do education a lot better than through the hospitals. So I just don't think we've had enough discussion on this.

DR. ROWE: I'm not actually talking about additional money. My guess is it's about the same amount. But I was considering this to go to hospitals. I thought we were talking about -- the topic of the conversation was payments to hospitals. It doesn't mean we can't have another recommendation that there also be payments to e-learning companies, or disease management companies, but I was trying to address the question of what should we do about hospitals.

DR. WAKEFIELD: But it was payment to hospitals for enhancing educational effectiveness, so that's what stretches this out a little bit from my perspective. What's the goal you're trying to achieve? If it's the end of that sentence then you might be looking beyond hospitals.

MR. HACKBARTH: Let m pick up on Alice's comment and maybe also hearken back to what Sheila asked earlier. There are things about this that I like, and basically what I like about it is it says that we need to be targeted and careful in how we spend Medicare dollars, and get specific tangible results and not just put a big box of money out there hoping we'll get good things. To me that's what this whole IME issue is about, so I really like that.

I am a little bit uneasy about designating the specific right purposes and implying certain types of recipients are going to get it, because I just don't think we've thought it through. Everybody is entitled, of course, to do what they want, but my inclination faced with this would be to say I like the basic premise and the direction but let's not go down the track too far specifying the purposes. Maybe just say something like, we need to phase this out. We need to direct it; there are unmet needs that are important in the care of Medicare beneficiaries and MedPAC and the Congress ought to look at what they are and develop a payment formula that's appropriate to those purposes, as opposed to starting to list them. That takes on a life of its own once you start to list them.

Is that similar to what you were thinking, Alice and Sheila? Does that make sense to people?

MS. ROSENBLATT: [Nodding affirmatively.]

MR. MULLER: I certainly value the effort to make more specific something that causes such debate as to what the purpose of the program is. I don't want to necessarily agree that what we call the empirical basis which is attached to a residency ratio is, as I said earlier, the only reason for which the IME purpose was intended. We've used it, as Bob knows and people have indicated, as a way of distributing the funds. That's not the only reason for which the IME purpose was intended. For those of us who feel it was intended for broader purposes, not to subsidize e-learning companies, therefore I think, like David, I'm against the staff recommendation because I think that's the best way to protect the broader purposes for which the IME was intended.

DR. REISCHAUER: Jack has my vote next year but I think what this discussion has proven is that this really isn't ready for prime time. MedPAC recommendations usually arise out of analysis; analysis of a problem, presentation of solutions. What we're having now is a recommendation in search of analysis and definition. I think I'm in favor of the staff recommendation. I suspect that I might be standing alone or with my chairman on that one. But should it pass, I would argue that we include in the text some kind of paragraph saying that there is this larger problem and that these resources are the sort that they could be devoted to resolving it; look next year.

DR. NEWHOUSE: I think I'm with Bob, so you won't be alone anyway. I just wanted to respond to Ralph briefly. This payment is not only -- the residents are not only for the purpose of distribution, but it greatly affects the total size of the pot. When this started out it was, as I recall, it was in the 1-point-something billions and it grew to around the 6-point-something billions because the residents per bed rose virtually everywhere.

I, like Bob, have a hard time swallowing that the subsidy for these purposes should come from the payroll tax and the trust fund rather than general revenues. But as I said before, if there is going to be a subsidy I think we ought to consider this. I'm concerned also about how one would derive the empirical cost of teaching. What we've derived are the empirical costs of teaching hospitals in this formula, not the empirical cost of teaching.

MR. HACKBARTH: Okay, before us on the screen we

have the original staff recommendation. All in favor?

All opposed?

And then abstentions?

So what's the total on that? Why don't you read off what you've got so we can just verify? Who do you have as yes?

MS. ZAWISTOWICH: As yes I have Glenn Hackbarth, Bob Reischauer, Pete DeBusk, Dave Durenberger, and Alice Rosenblatt, and Joe Newhouse.

MR. HACKBARTH: So that was six yes.

MS. ZAWISTOWICH: Right.

MR. HACKBARTH: Then read off your noes.

MS. ZAWISTOWICH: My noes are Ray Stowers, David Smith, Carol Raphael, Alan Nelson, Ralph Muller, Allen Feezor, Nancy-Ann DeParle, and Sheila Burke, and Jack Rowe.

MR. HACKBARTH: So that should be nine noes and then to have abstentions for 17.

Jack, do you want to offer your alternative?

DR. ROWE: I'm very sympathetic to the fact that this is not the result of detailed analysis. I'm unapologetic about it. It came up in the concept of our discussion about these issues. I didn't come thinking we were going to have a recommendation about it. I don't think we're going to accomplish anything by voting on this yes or no in terms of, is it ready for prime time and to be sent to the Hill. But since we spent so much of the Commission's valuable time discussing it I personally, and I think perhaps all of us would benefit from some assessment of whether people are supportive of the sense of this, and whether or not we should use this in an informal rather than a formal way as a stimulus for some additional analysis and conversation in the future.

I respect greatly everybody's input. I'm not trying to railroad this at all. But I'm not ready to wait till next year either to discuss it because I do have some sense that it is the proper way to go. So I would propose something along those lines if there is in fact in the methodology a way to do that.

MR. HACKBARTH: David, do you have a comment on this?

MR. DURENBERGER: Yes. As one who voted for the original recommendation and has had occasion to vote to cut IME after helping Sheila invent it and all the rest of that, I meant that vote.

By the same token, Jack's proposal accomplishes the same thing, plus it sends a message that might foster the reduction in the IME payment or the adoption of the staff recommendation by developing a value-based definition of empirical cost of teaching, which is kind of a newer added value. Now whether it can be measured or not measured can be debated for a long time.

But if the goal is to make the trust fund contribution to medical education actually produce medical education, then I think the first step in that process is to begin to reduce the amount of the trust fund that is not going into medical education. It's going to some other purpose that sustains teaching hospitals. If this is the vehicle, at least for this group to get on record with more than six people supporting a reduction in IME payments then my instinct is to support it.

DR. NEWHOUSE: I think we are actually on record, a former Commission as saying the empirical costs of teaching are borne by the residents and not by the Medicare program. That the additional costs of teaching hospitals go toward patient care. Everybody may not agree with that but it goes to -- I don't think there is any way empirically of establishing the empirical cost of teaching. That's based on a fairly well-accepted set of theories in economics, what I just said. But as I say, I think we could be here forever trying to decide -- do a study of the empirical cost of teaching.

MR. HACKBARTH: Here's what I propose we do. I like the concept but I would feel compelled personally to vote no on the recommendation because I don't think we've thought it through. I think it dilutes our credibility to make hasty judgments about important issues. So what I'd suggest is that we not vote on this, but rather take it as an agenda item. And not one for the long-term but actually try to spend some time quickly to think it through a bit. If we think we've got something solid and promising, we've got vehicles other than the March report where we can say something to Congress. We can write a letter, if that's the case.

DR. ROWE: Glenn, if I can make a suggestion that I think is consistent with that and at the same time takes advantage of the fact that we've had all this discussion, and that is that I would be happy to try to revise this statement and offer it tomorrow in a way that's crafted more

toward the fact that we should study this and that we should look at this is a particularly important opportunity, or something like that, and see whether that is something that would give us something a little more specific than a letter or a paragraph in the narrative or something like that.

MR. HACKBARTH: Let's do it.

DR. ROWE: But isn't a replacement recommendation.

MR. HACKBARTH: Yes, it's worth a try to do that.

DR. REISCHAUER: I didn't know if we were going to recommend something to ourselves. Is that what you're suggesting?

DR. ROWE: I thought I'd have a glass of wine and think about it, Bob.

DR. REISCHAUER: Two glasses and it will help your heart.

[Laughter.]

MR. HACKBARTH: Okay, so we'll table this for now and perhaps come back to it in the morning if Jack has something that he would like to offer.

So we now need to move on to the transfer policy recommendation. I think what we can do here is just vote sequentially one the two alternatives here. So all in favor of version A?

So the yeses that I see are myself, and Bob, and Joe, and Allen Feezor, Alan Nelson, and Jack.

Noes on option A?

I'll read them off to you. Sheila, Dave Durenberger, Ray, Mary, David Smith, and Ralph on this side, and then Nick, Alice, Nancy-Ann.

Any abstentions?

Pete, I'm sorry, I missed you. Which side were you on, yes or no?

MR. DeBUSK: No.

DR. MILLER: Can we do those one more time? Here's what I've got. On noes, Sheila, Nancy-Ann, Pete DeBusk, Dave Durenberger, Ralph Muller, Alice Rosenblatt, David Smith, Mary Wakefield, Nick Wolter. And I'm sorry, Carol.

MR. HACKBARTH: Any Ray Stowers. So what are totals?

DR. MILLER: Six yes, 11 noes. So that's everyone.

MR. HACKBARTH: So let's turn to variation B. We'll do option B, and I think it will be easier, as Sheila

suggested, if we just read off the names and do a roll call vote. So read down your list.

DR. MILLER: Glenn?
MR. HACKBARTH: Yes.
DR. MILLER: Bob?
DR. REISCHAUER: Yes.
DR. MILLER: Sheila?
MS. BURKE: Aye.
DR. MILLER: Nancy-Ann?
MS. DePARLE: Yes.
DR. MILLER: Pete?
MR. DeBUSK: Yes.
DR. MILLER: David Durenberger?
MR. DURENBERGER: Yes.
DR. MILLER: Allen Feezor?
MR. FEEZOR: Yes.
DR. MILLER: Ralph Muller:
MR. MULLER: Yes.
DR. MILLER: Alan Nelson?
DR. NELSON: Yes.
DR. MILLER: Joe Newhouse?
DR. NEWHOUSE: Yes.
DR. MILLER: Carol Raphael?
MS. RAPHAEL: Yes.
DR. MILLER: Alice Rosenblatt?
MS. ROSENBLATT: Yes.
DR. MILLER: Jack Rowe?
DR. ROWE: Yes.
DR. MILLER: David Smith?
MR. SMITH: Yes.
DR. MILLER: Ray Stowers?
DR. STOWERS: Yes.
DR. MILLER: Mary Wakefield?
DR. WAKEFIELD: Abstain.
DR. MILLER: Nick Wolter?
DR. WOLTER: No.
DR. MILLER: I think that's 15 yeses.
MR. HACKBARTH: So B it is.

Next is low volume. I think we resolved to include the 15-mile limit. So all in favor? I don't think we'll need the roll call on this. I hope not. All in favor of the low volume adjustment with the 15-mile limit. I think everybody's hand is up.

Next, labor share. All in favor of the

recommendation? All hands are up.

DR. NEWHOUSE: No, I'm abstaining.

MR. HACKBARTH: Just for the record, let me make sure I didn't miss anybody. Any noes on the labor share?

So we have 16 yeses and one abstention.

Nest, this is to go to a single base rate. All in favor?

Any opposed? Any noes?

Any abstentions? I don't see any. Do you want to put up the options, the two-year versus five-year? Increase the cap with a two-year transition. All in favor?

Opposed?

MS. DePARLE: That's the one where we were told that Congress, both houses had passed this as a five-year transition?

MR. ASHBY: No, one house had passed it as a five-year; one had only discussed.

DR. MILLER: But in both pieces of legislation, although one didn't pass, it was five years; is that correct?

MR. ASHBY: That's right.

MS. DePARLE: I vote no on the two-year.

MR. HACKBARTH: One no.

Any abstentions?

MS. RAPHAEL: I'd like to abstain.

MR. HACKBARTH: So we have 15 yeses, one no, and one abstention. Is that it for the rural package?

MR. ASHBY: For the rural package.

MR. HACKBARTH: Next is the inpatient update. All in favor of the recommendation on the inpatient update?

All opposed?

Abstentions?

Seventeen yes.

DR. MILLER: Is it correct we don't actually have a slide on -- or do we, on the outpatient one?

MR. HACKBARTH: On the outpatient update, all in favor of the recommendation?

Opposed?

Abstentions?

So seventeen 17 yes.

I think we are done with the voting and the recommendations.